Maternal and Child Health Services
Title V Block Grant

State Narrative for Kentucky

Application for 2013
Annual Report for 2011

Document Generation Date: Friday, September 21, 2012

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section. IA - Letter of Transmittal

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Assurances and Certifications for the Title V, Maternal and Child Health Block Grant are on file in the office of the Division of Maternal and Child Health. The division office can be contacted at 502-564-4830.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

E. Public Input

Public input for the Title V Block Grant is accomplished in many ways.

The Department for Public Health submits two copies of the Title V/Maternal and Child Health Block Grant application to the Legislative Research Commission (LRC) of the Kentucky General Assembly. After the grant submission each July, DPH presents testimony about the Block Grant to the Health & Welfare legislative committee each year before they approve the grant.

A link to the Title V/Maternal and Child Health Block Grant, as well as program service information, is on the Department for Public Health Website. A public hearing is scheduled annually for the DPH block grants, during July, prior to submission of the application. Information about the Title V Application process, overview of the purpose and data compared over multiple years is provided. A news release is sent from the CHFS Office of Communications to media within the state announcing the date and location of the public hearing. Title V staff are in attendance and are available for questions at each hearing. However, this is not the process through which the Title V Program obtains most of the public input.

DPH conducted 11 forums throughout the state in March -- May of 2009 that were attended by over 500 interested stakeholders, including LHD directors, CHFS partners, contractors, and providers. The forums covered many topics that were of interest to stakeholders since they had been identified by them through a web-based survey conducted prior to the forums. DPH distributed surveys in health departments in order to hear the voice of clients who are being provided services under Title V Block Grant. Surveys were available in English and Spanish. We received 3,200 completed surveys from patients that are currently being analyzed.

DPH distributes other surveys on a continuing basis in order to receive input from the populations served. The HANDS Parent Satisfaction survey is distributed annually in March. Surveys cover enrollment, interview process, and quality of services. First Steps surveys are mailed out annually in July to elicit information from parents reporting if they are being helped by the program, if families know their rights, and if families can effectively communicate their children's

needs and help them develop and learn.

The Division's program staff participate in many organizations, workgroups and committees across the state related to their programs which include their stakeholders, community partners, and consumers. Those efforts include, but are not limited to; the First Steps Interagency Coordinating Council (includes parent representatives and receives input from the public during quarterly meetings); the Kentucky Childhood Lead Poisoning Prevention Advisory Board which receives input from stakeholders and community partners; The Breast Cancer Advisory Committee; the Coordinated School Health Program which receives input from the public as well as community partners; Early Childhood State Advisory Committees (SEED, ECCS); State Interagency Coordinating Council for Services to Children with an Emotional Disabiity (includes teen and parent representatives);Partnership for a Fit Kentucky state coalition; Action for Healthy Kids; Community Early Childhood Councils; and Summits such as the Breastfeeding Summit and Teen Pregnancy summits held in Spring 2010. These interactions with public and private partners provide ongoing feedback and guidance to the Title V MCH program.

The Commission for Children with Special Health Care Needs obtained input from a wide range of people for their needs assessment, including their Youth Advisory Council, Parent Advisory Council, Parents as Partners, and Medical Advisory Council. On an ongoing basis, CCSHCN staff participate on councils and boards such as the KY Council on Disabilities, Center for Accessible Living, KY Speech-Language & Hearing Assiciation, Regional Interagency Transition teams, KY Special Parent Involvement Network (KSPIN), First Steps ICC, KY Interagency Transition Council for Persons with Disabilities, and others.

/2012/ DPH has had many invaluable opportunities to collect public input throughout 2010 and early 2011. Experience has demonstrated that public hearings are not a practicable method of collecting public input for MCH in KY, evidenced by very low to no turnout for several consecutive years. Numerous advisory councils continue on a regular basis. Of particular interest is the return of the 2nd Annual Teen Pregnancy Prevention Summit and the 1st Annual Breastfeeding Summit. Both sessions provided input from public and private health professionals, and consumers.

On the rise is the ability of PH programs to engage youth as leaders in issues particular to their age groups. DPH's Coordinated School Health (CSH) program in conjunction with the Department of Education and KY Action for Healthy Kids, have successfully implemented the Students Taking Charge in 25 high schools across Kentucky. High school students were represented and assisted in the program design and now serve as leaders in their schools to help improve nutrition and physical activity. CSH involved parents also through collaboration with the Kentucky Parent-Teacher Association in the Parents are VIPs workshop with well received evaluations in support of future endeavors. The Six Critical Health Behaviors of Youth Professional Development held in 2010 provided useful input from KY youth on barriers in schools for improving health education. Also, Partnership for a Fit Kentucky published the opportunity for youth to apply to their Youth Advisory Board through online media. CSH receives results of surveys Kentucky high schools conduct to solicit information from students, parents, and school staffs that is used to help schools develop health wellness policies. The KY SIAC (State Inter Agency Council) now has a youth representative and student regional advisories that present issues related to behavioral health. Recently KDE surveyed educators on preferences for use of social media and found 35% prefer Facebook as a means of promoting educational messages.

New for Oral Health in 2011 was the well-attended Oral Health Summit. Input was received from stakeholders, both professional, nonprofessional who provided insight into the barriers that exist in Kentucky for access to oral health care as well as suggestions for overcoming them. The Kentucky Oral Health Program (KOHP) is currently in the planning stage for a state-wide Oral Health Coalition.

/2013/ The KOHP trained four LHD staff to conduct focus groups in their local communities

to determine the attitudes, behaviors and beliefs of parents concerning oral health. From the community research, the staff developed Healthy Teeth, Healthy Smile toolkit which will be distributed to schools, LHDs, dental professionals and other community partners. The Access for Babies and Children Dentistry (ABCD) program developed training modules and has held several trainings throughout the state for general dentists on pediatric technique. The statewide Oral Health Coalition held its first meeting with over 75 attendees, and the second meeting is scheduled for Summer 2012. //2013//

The Child Fatality Review and Injury Prevention Program receives information for prevention strategies through many professional organizations but the program coordinator is active with many coalitions and board committees that interface with statewide and local health professionals and citizens in communities. Input received is important in learning what safety issues exist and what interventions are needed.

First Steps collects surveys from parents whose child received services to address three outcomes: First Steps helped the family know their rights, helped the family communicate their child's needs, and helped the family learn how to help their child grow and learn. Results of the annual survey are reported to the US Department of Education as part of the Annual Performance Report. Results are also used to make changes to the early intervention system to better support the families served by First Steps. As a family-driven system, this input is critical to develop services that are accessible and effective for families. For 2011, the program is piloting an online parent survey that has already received over 250 responses.
/2013/ First Steps now surveys parents both on-line and by mail. Results from respondants show that 98% of families participating in First Steps stated early intervention services have helped families know their rights; 98% report that early intervention services have helped the family effectively communicate their children's needs; 97% report that early intervention services have helped the family help their child develop and learn. //2013//

HANDS sites assist with soliciting valuable input from the perspective of parents and service providers through completion of two different satisfaction surveys which are completed on an annual basis. Each March the HANDS Parent Satisfaction Survey is distributed to participants actively receiving services and those who have been exited from the program over the past twelve (12) months. This survey gathers information from the families in regards to the quality, duration, frequency, and impact of services. The second survey, the HANDS Site Satisfaction Survey, is distributed at the end of the fiscal year to each HANDS site to gain input from program staff about the frequency and benefits of support received from TA services; the value of training opportunities; those areas of program implementation that require additional support; and the receipt / benefit of HANDS materials (brochures, posters, and Helping HANDS for Healthy Homes resources).

Local agencies distribute a WIC opinion survey to consumers and retailers that is summarized and returned to DPH WIC program.

/2012/The 2012 MCH Block Grant will be posted on the DPH website annually after review and acceptance by HRSA. //2012//

/2013/ A draft of the 2012 CCSHCN portion of the application and annual report was posted on the CCSHCN website and Facebook page, for three months. Once posted, a link to the document was e-mailed to all CCSHCN staff and to the CCSHCN Board of Commissioners. Consumers and stakeholders were notified of the posting through messages on well-populated e-mail distribution lists pertaining to CYSHCN, presentations at advisory committee meetings, and social media status updates. Comments were accepted directly via e-mail or phone, and a "Survey Monkey" link was created to accept more structured input.

CCSHCN received 18 comments via Survey Monkey and email. Comments received originated from CCSHCN staff and were positive and constructive, and there was support for the application and report. Following consideration of all comments, a summary document was prepared and distributed by e-mail to all staff. The document is included as an attachment. //2013//
An attachment is included in this section. IE - Public Input

II. Needs Assessment

In application year 2013, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

Kentucky continues to address the state priority needs. Although many initiatives are addressed in the Overview and Performance Measures, there are collaborations and efforts at the community level that may not be mentioned.

Obesity continues to be a challenge for all ages in KY making it worthy to note the community approaches that are accessible and affordable for all populations. Through Community Transformation Grants, two recipients in the state are implementing strategies for obesity and tobacco use reduction.
(1) The Louisville Metro Department of Public Health and Wellness in KY is receiving $721,594 to serve the large county of Jefferson, an estimated population of over 740,000. Work will focus on expanding efforts in tobacco-free living, active living and healthy eating, quality clinical and other preventive services, and healthy and safe physical environments.
They are working on smoke-free homes, starting with low-income housing units, food deserts-get better foods (vegetables/fruits) in areas where there is limited access, built environment-sidewalks, safe routes to school, walkable community initiatives, etc.
(2) Project UNITE (Unlawful Narcotics Investigation Treatment Education Coalition) in KY is receiving a $500,000 planning award to build capacity to support healthy lifestyles in the entire state of KY minus large counties, an estimated population of over 3,500,000 including a rural population of 1,800,000. Work will target tobacco-free living, active living and healthy eating, quality clinical and other preventive services, social and emotional wellness, and healthy and safe physical environments. In addition to hiring regional coordinators, they are planning three forums in the fall off 2012. Several DPH staffs are on their statewide board/advisory council and UNITE staff participate in the DPH Chronic Disease and Health Promotion strategic planning: Strategies include all the items listed in the description above.

The Nutrition Services Branch for fiscal year 2013 will be contracting with the Department for Community Based Services (DCBS) to provide SNAP (Supplemental Nutrition Assistance Program) education through the local health department to SNAP participants, those eligible and their caretakers. The amount of money for this endeavor is around $6 million.
As local SNAP-Ed providers, health departments will be delivering nutrition education and obesity education prevention services to a SNAP audience; assisting the SNAP-Ed audience in understanding how to eat a healthy diet on a limited food budget; building relationships with other appropriate local service providers who provide nutrition and health messages to SNAP participants so referrals can be made, as appropriate; and providing referrals to SNAP for other low- income non-participants who may come to the health department, as appropriate. SNAP-Ed interventions will be provided according to evidence based practices and approved protocols.

Substance Abuse
Efforts to address substance abuse and smoking in pregnant women and teens continue to develop and grow. Collaboration between DPH and the Department for Behavioral Health (DBH) continues to work toward development of a version of SBIRT (Screening, Brief Intervention, and Referral for Treatment) to assist providers in addressing substance abuse and smoking by pregnant women. Programs that address teen smoking continue to develop and grow in surprising numbers. DBH is hosting an ongoing workgroup on substance exposed infants and their management.

Students Taking Charge, a collaborative effort between Coordinated School Health (CSH) and

Kentucky Action for Healthy Kids has been employed in 38 high schools now across Kentucky, all of which have received $500 mini-grants to foster such focus areas as tobacco, school gardens, and physical activity and nutrition. The mini-grants are funded by a partnership between CSH and the Tobacco Prevention and Cessation Program (TPCP). The 24/7 Tobacco Free Schools collaborative effort, also between CSH and TPCP, has begun in 23 school districts comprised of 121 schools as of late spring 2012. More in-depth information on these programs can be accessed in the Physical Activity, Nutrition, Tobacco and Asthma (PANTA) Plus School Resources Guide online at http://chfs.ky.gov/dph/mch/cfhi/Coordinated %20School%20Health.htm.

Child Maltreatment deaths - See also State Performance Measure 4
KY continues to collaborate with partners around the state to address child maltreatment. DPH interfaces on a regular basis with the Department for Community Based Services, state medical examiners, Prevent Child Abuse Kentucky, the Kentucky Injury Prevention and Research Center, local health departments, and private providers and hospitals. The state will again attempt to request technical assistance to determine how we can better approach and prevent this issue.

Teen Pregnancy Prevention
A wealth of knowledge about teen pregnancy prevention was gained from the teen participants of the focus groups at the Annual Teen Pregnancy Summits and it has greatly impacted the direction of the teen pregnancy prevention program in KY. Significantly, the teens reported that they want sexuality education every year or every other year to reinforce what they know and they want their parents to be better equipped to communicate with them. Secondly, the teens reported that they want more to do with their time and that they want to be involved in their communities. The groups also stated that they want more ‘one on one' time with adults and that they need adult mentors who care. They stated that barriers to teen pregnancy prevention programs include a lack of time, a lack of funding, and a lack of volunteers and transportation.

Strategies developed by the Kentucky Teen Pregnancy Prevention Team (KTPPT) was established in 2010 include: state-wide age-appropriate sexuality education grades K-12 based on federal guidelines that includes accountability measures and minimum standards for educator training; all KY youth will have access to reproductive health care, contraceptives, and preventative services; educate and engage parents and communities to provide access and opportunities for positive youth involvement; and implement ongoing teen pregnancy prevention awareness utilizing multiple modes of communication.

Oral Health has been a subject of interest to the Governor, especially children's oral health, and activities are discussed later in this document. A major step towards improved access is the creation by statute of a Public Health Dental Hygenist.

Infant Mortality and Prematurity
KY has taken a leadership role in national and regional strategies to address prematurity and infant mortality as a result of the ASTHO challenge to improve birth outcomes by reducing infant mortality (IM)and prematurity in the United States. Following participation in the Regions IV and VI IM Summit, the KY IM State Team continues to meet monthly and is discussing multiple activities aimed at the care of prenatal women and infants. Notable partners on the state team, as well as others working collaboratively with the team include representatives from KY's Department for Medicaid Services, the Kentucky Chapter of the March of Dimes, the KY chapter of the American Congress of Obstetricians and Gynecologists, Primary Care Association, local health departments, the Kentucky Hospital Association, and DPH (Maternal and Child Health and Women's Health Divisions). Additional collaborations include the Office of Health Policy and the State Medical Examiner.

Projects currently being developed at the state level in support of the larger initiatives include a Progesterone Program for uninsured, data improvement projects, a Family Planning waiver/SPA, and placement of MCH coordinators in each local health department. Additionally, A Healthy

Baby Begins With You Kentucky! Project will enhance efforts to address infant mortality disparities among minorities in Kentucky. The project addresses preconception and interconception health messages that will target 18+ college age minority women at our states only Historic Black College or University (HBCU) Kentucky State University (KSU). The Project will utilize Healthy People 2020 objectives that relate to the project topics and guidance from the OMH Healthy Baby Begins With You campaign to implement activities.

CCSHCN continued to address priority needs identified in the last assessment, particularly those represented in State Performance Measures 7 (healthy weight among CYSHCN) and 8 (transitions program capacity). Internal committees toward both SPMs remain active.

Additionally, the agency has initiated a strategic planning process, the hope of which is to define how CCSHCN can participate in resolving issues that surfaced in the needs assessment but were not selected as SPMs. CCSHCN is interested in working collaboratively with partners and other agencies toward a "road map" for addressing the needs of CYSHCN in KY, and building for the next formal assessment. Towards this end, CCSHCN wishes to develop institutional structures or processes that inform solutions and lead to better methodologies of problem-solving and more effective data reporting. It is anticipated that technical assistance will be sought toward this goal.

There are no new needs identified, except for achieving stability and reaching a new "normal" in the face of severely reduced funding, and the state-wide implementation of the Medicaid MCO's. DPH overall is restructuring to a Core Public Health Service design in order to assist local health departments better address community needs and weather these storms.

III. State Overview

A. Overview

The Commonwealth of Kentucky (KY), nicknamed the Bluegrass State, became a state in 1792, the 15th of the United States. KY has a diverse terrain comprised of the Appalachian Mountain range to the east, fertile interior lowlands within the Bluegrass central area, and plateau to the west. The state is bounded by two of the largest rivers in the country, the Ohio River to the north and the Mississippi River to the west. KY is rich in agriculture ranking 5th in the nation for total number of farms per square mile. It maintains a farm-based economy in major crops of corn, soybeans and tobacco. The state is the leading breeder of thoroughbred racing horses and cattle and goat production rank 8th and 5th respectively in the nation. Industrially coal mines in the state are the most productive in the nation and Kentucky ranks 4th among U. S. states in the number of automobiles and trucks assembled.

There are 120 counties within the state that vary greatly in size, terrain, population, culture, and education. Much of KY is rural, with nearly 2/3 of the 120 counties in the state not having a city or town with over 20,000 people. Even with sparsely populated areas, nearly half of KY's population (42%) live in rural areas. This affects access to health care, access to higher education, access to employment, and access to services. There are 56 Appalachian counties designated by the CDC as a disparate population where poverty rates and these geographic challenges make access to care difficult and result in higher morbidity and mortality.

/2012/KY's total population is 4,314,113 (2009, Census Bureau) with a growth rate of 6.7% over the last nine years. As the population grows, it is becoming more racially and ethnically diverse. Overall, whites comprise 87.2% of KY's population, African-Americans represent 7.7%, and Hispanic 2.7%. Other groups comprise less than 2% of the population. However, KY's children are more diverse with 82.4% white, 9.6% black, and 4.4% Hispanic (2009, Census Bureau). A snapshot of CCSHCN's population of 7688 patients seen during FY 2010 shows a distribution: 81% white (including under 1% Amish), 8.7% Black/African-American, 5.1% Hispanic, 1.3% Asian, and 3.5% "some other race/combination"; and 95% English speakers, 3.6% Spanish speakers, <1% sign language, and 23 primary languages used by clients.//2012//

/2013/ KY's total population is 4,339,367 (2010, Census Bureau) with a growth rate of 7.4% over the last ten years. As the population grows, it is becoming more racially and ethnically diverse. Overall, whites comprise 87.8% of KY's population, African-Americans represent 7.8%, and other groups, including those of unknown race, comprise 4.4% of the population. Of KY's total population, 3.1% are of Hispanic ethnicity. KY's children are more diverse with 81.3% white, 9.2% black, and 4.7% Hispanic (2010, Census Bureau). //2013//

By most every measure, the health status of Kentuckians ranks in the lower half, frequently the lower quartile in the nation. The framework of the Life Course Perspective of Health Development (Lu and Halfon, 2003) is helpful in understanding this. The Life Course model plots a course for a person's or a population's health trajectory across the life span. The slopes of the trajectory of health status at different life stages are determined by the balance of the number of protective factors (upward arrows) that "push up" and risk factors (downward arrows) that "push down" on the trajectory. Along this trajectory, there are critical periods of development, times at which toxic metabolic or social environments and adverse experiences can disrupt development and result in impaired functioning of an organ or system for the rest of the person's life. However, when persistently experiencing these adverse experiences over the life course as chronic stressors, there is a cumulative "wear and tear" on the body, depleting the allostatic system (the body's ability to adjust to stress). Thus, chronic and repeated stresses over the life course may lead to increased risk for cardiovascular diseases, cancers, higher mortality rates, autoimmune disorders, and a host of chronic adult diseases that contribute to poor health status and health disparities.

In MCH, we are aware of the critical periods of development and the opportunities to have a positive effect with interventions in those periods, particularly in pregnancy and early childhood. However, for a large segment of KY's population, it is more likely the cumulative load of chronic stressors that leads to this flattened trajectory of health development. Economic stressors predominate, mainly in the Appalachian region. In KY, 21% of people live in poverty, compared to 18.3% nationally. For KY children, nearly one in four live in poverty. Median household income is 20% below the national rate. Unemployment has jumped from 6.6% in 2008 to over 10% in 2010; in some counties in eastern KY, unemployment is over 17%. A ranking of state's economic distress puts KY at 48th [Kaiser]. The uninsured are 14.8% of KY's population, but due to the commitment of state policy makers, only 9.5% of KY's children are uninsured, which is better than the national average. The association between lower educational levels and chronic stress is well known. People with lower educational levels are less likely to be employed, to have adequate incomes, and to have health care access and coverage. Vital Statistics Birth Certificate Data from 2008 showed that 21.1% of KY mothers had less than 12 years of education. Todd County in western KY has the highest percent of mothers with less than 12 years of education at 41.8%.

A major chronic stressor for Kentuckians is smoking. As one of the leading tobacco producers in the country, the prevalence of tobacco use in KY is one of the highest in the nation. Nearly 1 in every 3 adults smoke, and the health impact (downward arrows) impacts rates of cancer, COPD, SIDS, Asthma, Cardiovascular disease, preterm birth, and many other morbidities. Teen smoking is now about 25%, and smoking in pregnancy is second highest in the nation at 28%. With the Life Course perspective (LCP), we can anticipate that the adverse effects of smoking, both physiologic and psychologic, are cumulative over the life course, and in indeed lead to a declining health status and premature death. Smoking rates are higher in those with lower socioeconomic and education levels, which only increased their risk and the likelihood of a lower health trajectory from cumulative effects.

The LCP helps us to understand that stress should be measured not simply in terms of stressful life events, but also the chronic social stressors that are pervasive in the everyday lives of Kentuckians. In environments of geographic isolation, economic depression, educational underachievement, and high rates of tobacco use, the lower health trajectory of many Kentuckians is understandable. However, we can also use the Life Course model to develop better approaches to health for Kentuckians despite these chronic stressors.

KY has presented the LCP Health Development Model to partners, policy makers and legislators using our HANDS Home Visiting program as an example. The HANDS program began in 1998 and was intentionally designed as a strengths-based program. Home visitors work with high risk first time mothers or dads on not only general health and child development, but also on skills to build family self-sufficiency. These include caring relationships, problem solving, conflict resolution, ability to access resources, good mental and physical health - the positive protective factors that build resilience and raise the trajectory of health status. Program evaluations show that participating families, compared to a similar group, have less preterm birth, less low birth weight infants, less substantiated child abuse and neglect, less emergency department utilization, improved education levels, improved employment, and improved family self-sufficiency. This is the Life Course model in action, working on the positive protective factors rather than trying to eliminate risk factors which are beyond our control. We do not raise these families out of poverty, move them to more affluent communities, nor make them into college graduates, but the program does give them skills to cope with their chronic stresses, even in the short timeframe of a pregnancy, that can lead to improved birth outcomes.

The LCP provides a longitudinal account of the interplay of biologic, behavioral, psychological, and social protective and risk factors producing adverse health outcomes. Lu and Halfon posit that closing the gaps in disparate health trajectories will require" 1) closing the gap in one generation to give the next generation an equal start, 2) targeted interventions during sensitive developmental periods (e.g., in utero development, early childhood, puberty, pregnancy), and 3) risk reduction and health promotion strategies across the life span." Some of our programs that

work towards these ends, through the life course, are as follows:

PRECONCEPTION
Preconception care has been recommended for more than a decade, but the LCP better explains why interventions only during pregnancy may not be the most successful way to have healthy pregnancies. Women must be healthy before and after pregnancies. The Women's Health Divison, described later, is taking the lead in enhancing "well woman" services and promoting preconception care.

KY Folic Acid Program (KFAP): KY provides all women of childbearing age access to the B vitamin Folic Acid through LHDs. Consuming folic acid prior to becoming pregnant can prevent 50-70% of neural tube defects. According to the CDC the annual medical care and surgical costs for persons with spina bifida in the U.S. exceed $200 million, and the approximate lifetime cost for an infant born with spina bifida is $532,000 and for many children the cost may be well above $1,000,000. For the past six years the estimated annual cost to KY residents is 12.1 million dollars. The KFAP is part of the KIDS NOW initiative. Currently about 58,000 women of child-bearing age annually have received folic acid counseling and/or supplementation.

/2012/Across KY 74,360 women of childbearing age received folic acid counseling and/or supplementation, through the efforts of the LHDs and contract agencies, including four state universities from July 1, 2009 through June 30, 2010. To date for FY2011, 54,690 women of childbearing age received folic acid counseling and/or supplementation, through the LHDs, contract agencies, and universities from July 1, 2010 through April 30, 2011.//2012//

/2013/ In FY11, KY provided folic acid counseling and/or supplementation to 69,162 women. To date for FY12, 55,279 women have received folic acid counseling and/or supplementation through LHDs, contract agencies and university programs. //2013//

Family Planning (FP): The CDC's recommendations for preconception care start with planned pregnancies. The FP Program provides services and referrals for smoking cessation, nutritional counseling, substance abuse counseling, and other preventive health programs. KY has a total of 173 FP clinic sites in all 120 counties for FY 10. All local health departments (LHD) provide FP services. KY FP clinics offer Limited English Proficiency (LEP) services through an onsite interpreter or a contracted interpretation phone service. FP clinics provide community outreach strategies through health fairs, newspaper and radio advertisement, counseling students on services within the schools, and pamphlets.

/2012/January 1, 2010 - December 31, 2010, KY's FP Programs served 96,881 females and 6,898 males, a total of 103,779 unduplicated clients. KY identified a duplication of users within the data collection system for LHDs in previous FP Annual Reports (FPAR), including calendar year 2009. The corrected total unduplicated clients seen in 2009 were 105,276, a decrease of 1,497 clients in 2010 or a 1.4% decrease. A total of 90,279 (87% of all clients served) were at 150% or below the federal poverty income level (a 6.1% increase from 82% CY 2009). According to the 2008 Guttmacher Institute's calculations, KY has 264,900 low income women in need of contraceptive services and supplies. KY met the contraceptive needs of approximately 37.4% of its women in need of FP services. The state Title X staff continues to provide ongoing technical assistance to FP clinics and continue to monitor activities through process evaluation and program outcome data.//2012//

/2013/ For CY11, KY's FP Programs served 96,203 females and 8,048 males, or a total of 104,251 unduplicated clients and of these, 75,150 individuals (or 72%) were at or below 100% of FPL. A total of 90,035 individuals (or 86%) were at or below the target population of 150% FPL. A total of 71,004 (68% served) were uninsured, 25,520 (24% served) were Medicaid, and 6,599 (6%) private insurance. A total of 20,207 clients (19.4% served) were under 19 years old. The total of white clients were 89,672 (86% served), 11,624 were African-American (11.2% served), and 7,939 were Hispanic (7.6% served). PRAMS Data

from 2009 demonstrates the highest levels of unintended pregnancy in 20-24 year olds at 71.7% and 51% in 25-29 year olds. This group makes up the majority of KY's births, as well as 63% of all female family planning users. Medicaid recipients had an unintended pregnancy rate of 74%, uninsured individuals had a rate of 77.3% and those with private insurance had a rate of 46.6%. //2013//

PERINATAL
Prenatal Program (PN): The Title V program provides funding to LHDs in all 120 counties to assure care is available for low-income and uninsured individuals. Currently 17 LHDs have in-house PN clinics, but most have been able to partner with local providers to assure care for pregnant women. Major PN health issues such as prematurity, gestational diabetes, smoking in pregnancy, domestic violence, postpartum depression, perinatal HIV transmission, and substance abuse in pregnancy are consistently addressed in the LHDs. DPH provides annual training and updates to LHD staff on current PN guidelines for care, including prematurity prevention and smoking cessation. PN guidelines for LHDs are provided in the PN section of the Public Health Practice Reference and follow recommendations from ACOG and AAP.

Healthy Babies are Worth the Wait (HBWW): An innovative approach to prematurity prevention that by design addresses the multiple determinants of preterm birth. It began as a partnership with March of Dimes (MOD) and Johnson & Johnson and the KY DPH in 2007, and now is being expanded to other sites. Community health leaders, including hospitals and health departments, work together with local MOD to implement multiple interventions known to reduce preterm birth, and improve systems of care in their communities. Target audiences are health care providers, pregnant women, and the general public, as prematurity affects the entire community. The pilot involved 6 communities, three intervention sites and three comparison sites. Materials include a Community Toolkit for Prematurity Prevention, which provides handouts, talking points for different audiences, powerpoint presentation, and instructions on how to approach community partners. All materials are available on the web site, in English and Spanish, at www.prematurityprevention.org.

/2012/In 2010 the comparison sites became implementation sites along with the Barren River District HD and their two birthing hospitals. This brings the numbers of communities/hospitals affected by HBWW to eight locations.//2012//

Fetal Infant Mortality Review (FIMR): Two FIMR projects are currently underway in KY. One is in Louisville, which has the state's largest African American population, and the second in Bowling Green, KY, where there is a significant Hispanic population. The review teams in these areas will provide more accurate data on fetal and infant deaths along with the identification of risk factors and potential prevention strategies. System barriers that may influence infant mortality may be identified and addressed by the community team members.

/2013/ HBWW has been transitioned to a national MOD educational campaign and service package, and inspired the ASTHO "Healthy Babies" President's Challenge; KY continues with 8 active sites. KY FIMR projects have been reduced or eliminated due to funding cuts. //2013//

Newborn Screening (NBS): Approximately 57,000 infants are born in KY each year. KY law mandates that all infants born in KY receive newborn metabolic screening. The Title V program assures patients and providers receive adequate information, contact is made between the University specialty clinics and the community medical home, and that short and long term follow up testing is completed. The NBS collaborates with the State PH Laboratory, pediatric specialty clinics at UL, UK, Cincinnati Children's Hospital, and Vanderbilt University, primary care providers, LHDs, birthing hospitals, Medicaid, the HRSA Region 4 Genetics Collaborative, KY's NBS Task Force, CFR, the KY Birth Surveillance Registry (KBSR), the MOD and the National Newborn Screening and Genetics Resource Center.

/2012/NBS works with the KY Metabolic Foods and Formula Program to partner with durable medical equipment providers, pharmacies, and families in assisting those diagnosed with inborn errors of metabolism and genetic conditions in obtaining therapeutic foods, formulas, supplements, and low-protein modified food products for the uninsured.//2012//

EARLY CHILDHOOD

Women, Infants, and Children (WIC) Supplemental Nutrition Program

The federally funded WIC Program sets the standards for nutrition services. WIC's primary focus is to provide nutritious foods, nutrition education and, when appropriate, breastfeeding information and appropriate social and medical referrals for low-income pregnant, breastfeeding and postpartum women, infants, and children who are at nutritional risk. WIC is available in all 120 LHDs, and several health department satellite sites. WIC serves approximately 140,000 women, infants and children per month. The program is actively promoting breastfeeding. WIC has a breast feeding peer counselor support program in 14 sites across the state. WIC sponsors the state breastfeeding coalition and is developing the state plan for breastfeeding.

Health Access Nurturing Development Services (HANDS)

HANDS is a voluntary home visiting program for first time moms or dads who are identified with two or more risk factors on a screening tool. HANDS is available in all 120 counties through the LHDs, and works with community partners to assure awareness of the program and make referrals when appropriate. HANDS will accept families referred any time during pregnancy or up to 12 weeks after the baby is born. Professional staff do a comprehensive assessment of the family and family support workers who have been trained with a curriculum then address the family's needs. Parent-child attachment and bonding, parenting practices, problem solving, resource management, and health education are included. HANDS makes referrals to/for basic needs, child care, domestic violence, education, employment, First Steps, LHDs, mental health, oral health, physician care, smoking cessation, substance abuse and transportation. Local HANDS staff participate in community collaborative groups, with public and private partners.

/2012/In 2010, HANDS home visitors completed a total of 166,306 visits to over 10,600 families, with a projection of over 195,000 home visits for 2011. Major renovations have been made to the HANDS web system now allowing direct submission of patient surveys and technical assistance site visit summaries. KY secured funding to strengthen and improve coordination of services for "at-risk" communities with maternal, infant and early childhood home visitation.//2012//

/2013/ Professional and paraprofessional home visitors completed a total of 167,393 visits in fiscal year 2011. At the end of fiscal year 2011 KIDS NOW reports indicate a total of 10,614 families received HANDS services with 6,303 assessments completed, an increase of 475 from fiscal year 2010. There were 74,186 professional visits, also an increase from the previous fiscal year by 6,341 and 93,207 paraprofessional visits, an increase of 574 visits from fiscal year 2010.

The KY DPH was awarded funding through Affordable Care Act, the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV), allowing for expansion of services to multigravida moms, linking al programs through a Systems of Care, and the addition of in-home perinatal depression treatment. Approximately 48 counties are included in this expansion of care. //2013//

KY's System to Enhance Early Development (KY SEED)

In October 2008, KY was awarded a six year cooperative agreement between the Substance Abuse and Mental Health Services Administration and the DBHDID to further KY's development of its system of care for children age birth to five who have social, emotional, and behavioral needs and their families. The State Implementation Team is composed of strong representation from Public Health including representation from the following MCH Programs: First Steps, HANDS, ECMH, and CCHC. Local implementation teams have the same membership but local staff.

/2012/KY SEED provided funding to enhance universal developmental screening efforts by purchasing learning activity manuals in English and Spanish to assist in the identification and treatment of developmental delays and social and emotional issues.//2012//

Early Childhood Mental Health (ECMH)
The ECMH Program is funded through KIDS NOW. The goal of the program is to support the social and emotional growth of KY's children birth to age five by emphasizing the importance of nurturing relationships in multiple settings. This program trains and funds ECMH specialists in each of the mental health regions in the state. Services provided by the specialists include assessments, therapeutic services, training and resources for public and private providers. Additionally, the specialists provide and sponsor training and consultation to child care providers and fellow clinicians to assure high quality care and increase the number of qualified professionals serving these children. Approximately 400-500 children are served each year. Collaborative partners include: KDE (Division of Early Childhood Development), Division of Child Care, local Community Early Childhood Councils, local Child Care Resource and Referral Agencies, State and Regional Interagency Councils (SIAC & RIAC), LHDs including programs like HANDS and CCHC, First Steps, KY Partnership for Families and Children, and KY SEED.

/2012/In 2010, 30 Community Mental Health Center therapists were trained in Parent Child Interaction Therapy and for FY11 has contracted for further ECMH Consultation with UK.//2012//

First Steps, KY's Early Intervention System (KEIS) is administered by the Cabinet for Health and Family Services and is mandated by the Federal Part C program to serve children from birth to age 3 with a developmental delay or a specific medical condition that is known to cause a developmental delay. First Steps services are voluntary and provided statewide by over 1,200 providers who are involved in direct service provision to children and families. Point of Entry sites in each region administer the program for their district; these include health departments and mental health centers. For 20 years, KY has delivered early intervention services to approximately 10,000 children each year.

Reach Out and Read (ROR)
ROR is funded by KIDS NOW, and works with pediatric health care providers including LHDs, pediatricians, and Family Practice providers to help raise pre-reading skills among young children of low income by educating parents about the value of reading to children. ROR provides developmentally appropriate books to take home at each pediatric visit from 6 months to 5 years. Sites must serve a significant number of impoverished children. Many sites are in located in LHD clinics, community health centers and other clinics serving children and families with Medicaid or who are uninsured. The KY ROR program serves over 37,000 children during their 75,000 Well Child visits and has provided over 65,000 books since December 2007.

/2013/ KY's 75 sites at 87 clinical locations served over 51,837 children during well child visits and provided over 92,362 books in 2011. Since 2007, 321,764 books have been provided to children of KY through the ROR program. //2013//

KY Oral Health Program (KOHP)
The KOHP works to improve the oral status of all Kentuckians and houses programs that target that goal. The Community Fluoridation Program works with municipal and private water systems to assure compliance with KY's state-wide law that requires fluoridation at optimal levels to reduce decay rates in the state. KY has the highest rate of municipal system customers having optimally fluoridated water than any other state in the U.S. KOHP supports LHDs for the provision of fluoride varnishes and dental sealants to their clinic-and school-based patients. Up-to-date training in dental development and disease prevention is provided to public health nurses throughout the state. KOPH has also collaborated with the KY Chapter of the AAP to train pediatricians and their nurses to provide fluoride varnish treatments, which are now reimbursable through Medicaid. Through a contract, KOHP supports and partially funds preventive and

restorative outreach services of UK's College of Dentistry to underserved children through their mobile dental vans and remote clinics/teaching sites.

Developing community oral health coalitions will provide solutions to barriers regarding the lack of access to dental services. Sustainability of the coalitions lies in training on strategies to increase the awareness of oral health knowledge and advocacy skills to create social change towards oral health. Twenty-five community oral health coalitions have been provided seed funding. These coalitions are funded through grants from the federal Health Resources and Services Administration (HRSA) and the quasi-federal Appalachian Regional Commission.

To address access for children in rural areas, the KOHP is developing a training program that offers a general dentist practical training in pediatric techniques so that they will see this young patient population. This is funded by HRSA, yet receives an enhancement grant from ARC to target the dentists in the ARC geographic area to participate. This will increase access for children in need to dental care. The development group is using the Washington State ABCD program as a template of success for the training curriculum.

/2013/ With the support of the Governor's office and funding from ARC, the KOHP developed a school-based flouride varnish program for elementary children in 16 of KY's highest need counties. Plans are underway to expand this program.//2013//

SCHOOL AGE CHILDREN
EPSDT / KCHIP Outreach
The KY Department for Medicaid Services (DMS) contracts with the DPH to provide funds to LHDs with facilities in all 120 KY counties to support clinical and community outreach for the EPSDT Program and participants. More than 360 LHD administrative, support and nursing staff provide EPSDT outreach services to families of eligible children statewide. Families are verbally notified of the value and necessity of EPSDT services by phone, written notice, home visits or during clinic visits for other health department services. These community EPSDT outreach workers encourage families of eligible children to obtain screening services through KenPac, community providers, and, if no community provider is preferred or designated by the family, help them make EPSDT appointments at LHDs if desired. The EPSDT Program works with DMS, other public health programs (Lead, Oral Health, WIC, HANDs, Immunizations, Family Planning), the KDE and Passport Health Plan. LHDs maintain working relationships with county and city schools, local agencies of DCBS and health care practitioners who provide direct services to EPSDT participants.

LHD EPSDT and HANDs programs throughout the state have partnered in FY 10 with the KCHIP Outreach programs in DPH and DMS to help meet the goal to increase Medicaid and KCHIP enrollment by 35,000 children through June 30, 2010. DMS and DPH have engaged LHDs and statewide providers through training opportunities to promote KCHIP enrollment as they conduct health care services among families of underinsured or uninsured children. Families are contacted by LHDs face to face in clinic settings or by phone or home visit and presented with opportunities and assistance to complete KCHIP applications. Other partners and stakeholders include but are not limited to community schools, Family Resource and Youth Services Centers, and DCBS offices, as well as the United Way, the Hagar Foundation, Covering KY Kids and Families, KY Voices for Health, KY Youth Advocates, KY Council of Churches, Catholic Conference of KY, Louisville Jefferson County coalition and Passport Health Plan.

Child Fatality Review (CFR)
CFR is critical to preventing injury and death to children in KY and combines the expertise of the local coroner, LHD, DCBS, law enforcement, and other critical partners. By working as a team, these agencies gather information that may have otherwise been missed had the death not been reviewed. The local CFR team is critical in helping the coroner determine the exact cause of

death, ensuring that other children in the home are safe, assuring grief counseling and community resources are offered to the family, identifying factors that may affect other children, and ruling out intentional injury. Prevention efforts such as the HANDS program, state and county SAFE KIDS coalitions, and CFR, address motor vehicle injury and child related deaths. MCH serves as the lead agency for the state SAFE KIDS coalition and provides technical support for chapters around the state. LHDs offer car seat checks, assist with train-the-trainer education for certified child passenger safety instructors, and partner with other agencies such as Drive Smart, the Governor's Highway Safety Program, the State Police, and the Transportation Cabinet.

Injury Prevention
DPH contracts with UK to administer the KY Injury Prevention Research Center (KIPRC). The Title V MCH Program funds a pediatrician injury prevention specialist, who provides technical support the LHDs to develop child fatality review teams to reduce child injury and death across the state. Through KIPRC, deaths and serious injury are investigated and findings are used to develop practical public health initiatives through education, programming, policy initiatives, surveillance, risk analysis, direct interventions, and evaluation. DPH also contracts with the Norton Regional Poison Control Center that provides 24-hour, seven day a week access to poison information for consumers and professionals. This contract also allows public and health professional education.

Coordinated School Health (CSH)
KDE and DPH are working together, along with other state partners, to help children be healthy and ready to learn, to achieve and be successful, productive citizens. KDE and DPH have developed a unique partnership through the funding of a CSH grant by the Centers for Disease Control and Prevention(CDC), Division of Adolescent School Health whereby staff from both departments work together as a team to coordinate school health policy and program efforts. This CSH Team helps school districts, LHDs and their community partners improve their school health programs by implementing "promising practices" as recommended by CDC. CSH consists of an eight-component model that recognizes how health, wellness, environment and learning are related. This national CDC CSH Eight Component Model is comprised of: health education, physical education/physical activity, health services, nutrition services, family and community involvement, staff wellness, healthy and safe school environment and counseling, psychological and social services. Promising practices include monitoring health-related behaviors, programs and policies. Data and evaluation sources include the administering of the KY Youth Risk Behavior Survey (YRBS), administering PROFILES (system of surveys assessing school health policies and programs in middle and high schools), School Level Impact Measures (SLIMS-measures of the percentage of secondary schools in a jurisdiction implementing policies and practices recommended by CDC to address the critical health problems faced by youth), program process measures and success stories.

Well Child/School Health
Preventive well child health services to promote and safeguard the health and wellness of all children are provided though LHDs across the state. University pediatric and obstetric programs are contracted to provide expertise and trainings to the health department staff for programs the state provides through the LHDs. Protocols for health department staff to follow for well child visits are in the Public Health Practice Reference and are aligned with Bright Futures and AAP Guidelines. LHDs collaborate with local school boards for the provision of preventive health services in satellite clinics within the school setting, which promotes improved access to health information and preventive health services for school age children. School health services provided by LHD staff have increased significantly in the last 3 years and are now one of the leading services offered by LHDs in their local communities. University tertiary care centers provide evaluation and service planning for children ages three to 16 with developmental concerns. Services make available developmental experts in the field of pediatric specialties and assure that KY children will have accessible services to identify, diagnose, and treat complex high risk conditions to prevent or minimize disabilities. The tertiary care centers provide various support services to families as well as professional guidance, consultation, and training to

community physicians and other health care providers on the care and needs of these children.

Pediatric Obesity
Collaborative efforts regarding pediatric obesity have been accomplished through MCH programs such as WIC and CSH (further described in the State Priorities Narrative). Capacity in this area has been improved. Both university pediatric programs have begun multidisciplinary clinics for obese children; the KY chapter of the AAP has several initiatives to train pediatricians to address obesity in their offices as a quality improvement activity; the Partnership for a Fit KY continues to work at the state and community level on environmental change. Policy makers are aware of the issues and have proposed mandatory physical activity in schools (not passed yet). The Title V program hopes to further advance these initiatives until we see a change in this adverse trend.

/2013/ The Partnership for a Fit Kentucky and the Shaping Kentucky's Future Collaborative released a new report called Shaping Kentucky's Future: A Community Guide. The report features stories of Kentuckians who have made physical activity and healthy eating easier and more accessible and sustainable in their communities. The stories detail practical projects such as how to develop a walking trail by mowing a strip of land and how to improve concession stand offerings at community pools. To make it easier to replicate these great ideas, the report includes persuasive language to use in selling the ideas, advice from those who led the initiatives, contact information and the best resources and reference on the topics covered. The stories featured in the report demonstrate and encourage communities to make sustainable changes through policy, environmental and systems change.

The KY Board of Education approved the proposal to require schools to calculate and record children's BMI, during annual exams in grades preschool through five, and at least once in middle school and in high school. This information will be accessible to parents and may provide a safety net for children without health insurance by assuring their weight issues will be addressed. The BMI was added to the Individual Preventive Healthcare form completed by school nurses who are encouraged to enter the information into Infinite Campus. Because this is a transition year, more reliable information will be available in future years. //2013//

Childhood Lead Poisoning Prevention Program (CLPPP)
CLPPP offers a comprehensive approach to preventing lead poisoning in children less than six years of age. Statewide services provided by Medicaid's EPSDT and Well Child programs, the WIC program, and private providers assist CLPPP in identifying children with elevated blood lead levels. CLPPP collaborates with other state and LHD programs such as HANDS, Asthma Prevention, Environmental Lead, OSHA, EPSDT, and Prenatal. CLPPP provides health education to local communities by offering information and materials to provider associations including KY Medical Association, KY Pediatric Society, and KY Rural Health Association, as well as community health fairs and conferences. KY State Fair, where CLPPP distributes over 1000 pamphlets and "freebies" each year is, the largest outlet for educational information targeting parents and families. CLPPP is currently working with CDC to transition into a more holistic "Lead and Healthy Homes" program. This new program will integrate lead poisoning prevention with other programs focused on improving health outcomes by correcting housing issues. These programs will include but are not limited to Radon, Asthma Prevention, Injury Prevention, mold, and vector control.

/2013/ Through the Healthy homes CLPPP Strategic Plan, protocols are being developed to expand assessments for other potential hazards in addition to lead. Families will receive referral information to agencies that can educate on ways the family can reduce their exposure to potential hazards such as mold, pests, radon, second-hand smoke, injury, and contaminants. With the reduction of funds at the federal level, the CDC has eliminated funding to states for this program. KY DPH will continue to maintain KY's HHLPPP and make every effort in promoting at-risk lead screening, lead data surveillance and case

management coordination for children with EBLL's. //2013//

ADOLESCENT/ADULT

TEEN PREGNANCY
Both teen pregnancy rates and teen birth rates are typically higher in KY than national rates. Since 1999, the KY rate for teen pregnancy for teenagers 15 -17 years old has shown an overall downward trend. After a downward trend in preceding years, KY's teen birth rate for teenagers 15 -19 years old increased in 2006, from 47/1,000 in 2005 to 54/1,000. According to preliminary data, the 2009 teen birth rate is 52/1,000. In the Title V Needs Assessment, teen pregnancy was one of the leading concerns in communities across the state. Several LHDs are involved in more intense efforts to address this issue.

Technical assistance funding in the amount of $1,238 was awarded to the Division of WH from MCHB for a technical consultant who provided technical assistance for teen pregnancy prevention and positive youth development at KY's Teen Pregnancy Prevention Summit on May 10, 2010. Included was information on how to connect with adolescents and positive messages that encourage young people to think and be smart. He also provided avenues to show young people that the messages they receive from media is deceptive, and how to help them make good choices. The TA provided the attendees (health educators, school educators, youth workers) with a renewed interest in the students with whom they work and a feeling of empowerment to make a difference in the lives of the teens of KY.

/2012/KY's teen birth rate declined 14.3% from 2008 with a 13% decrease for ages 15-17 in 2010. While encouraged by this decrease, we realize there is much more work to be done. Teen birth rates for the Appalachian counties continue to be somewhat higher than the state rate but in 2009 the Appalachian rate dropped 6.25%. The Division of WH directs the teen pregnancy prevention efforts of DPH through the Adolescent Health Initiatives Coordinator. WH administers the Title V State Abstinence Education grant and the Personal Responsibility Education Program (PREP) grant. They have awarded 47 LHDs/districts (LHD) and 3 community-based organizations representing 75 counties to teach selected curriculum in 249 middle schools and high schools across the Commonwealth. The program coordinator oversees the utilization of Title V Block Grant funds by LHDs for teen pregnancy prevention. Collaborative efforts are encouraged on the local, regional and state level. Partners for teen pregnancy prevention include the KY Teen Pregnancy Coalition, KDE, CSH, Family Resource and Youth Service Center staff at each school, local coalitions, LHD health educators, school teachers, school administration, and community-based organizations.//2012//

/2013/ KY teen birth rates indicate a decline for 2010 of 16.3% from 2008, dropping from a rate of 55.2 in 2008 to 46.7 in 2010. The rate in Appalachia counties is down 14.9%, from 62.4 in 2008 to 53.1 in 2010. //2013//

YOUNG PARENTS PROGRAM (YPP)
The Adolescent Health Specialist at UK is funded by the DPH Divisions of WH and MCH to provide comprehensive services for first time parents and pediatric services to their infants, reporting the outcomes of their patients to MCH. The YPP provides medical and psychosocial services to adolescents who begin prenatal care at the KY Clinic Obstetrics Clinic prior to their nineteenth birthday. Services include: prenatal, postpartum, and child development assessments. YPP provides family planning services to teens and male reproductive health services for pregnancy and STD prevention, along with other preventive services, reporting outcomes to WH. The YPP provides comprehensive sexual education, including abstinence, at mutlitple school sites. The YPP reduced the repeat teen pregnancy rate to less than 1% of teens in the program. The YPP provides a statewide conference on "Stop Youth Suicide Campaign" as well as training for UK's OB/GYN and Pediatric medical students and residents. and provides clinical family planning services at the UK Adolescent Clinic.

/2012/In 2010, 65% of mothers entered YPP prenatal care in their first trimester with an average number of prenatal visits of 7.5. There were 16.3% of low birth infants born to program participants and 41.9% of YPP teens who delivered attended a postpartum visit by the 42nd day after delivery. 76.7% of YPP infants returned for their first scheduled well child checkup. The YPP clinic served 2,108 patients last year.//2012//

SUICIDE PREVENTION
KY Department for Behavioral Health (DBH) Suicide Prevention personnel serve as support to KY Suicide Prevention Group, including assistance with public relations and presentation workshops, advocacy workshops, suicide survivor conferences and other survivor supports and resources, State Fair booth, manning and other assistance as needed, basic monthly meeting and additional support as needed. DBH Suicide Prevention personnel serve as coordinator of QPR (Question, Persuade, and Refer) trainers, including trainer certification trainings, scheduling trainings, trainer recertification, etc. There are currently 150 active QPR trainers in KY. Suicide prevention members attend DPH's CFR state meetings likewise DPH staff members attend suicide prevention meetings and activities.

HIV/AIDS
This education, counseling and testing program is responsible for the development and monitoring of all counseling and testing sites across the state. All county health departments and many other professional agencies offer free anonymous or confidential HIV tests. The KY HIV/AIDS Services Program is funded through the Ryan White HIV/AIDS Treatment Modernization Act of 2006. The Ryan White Part B Program was created to address health care and service needs of people living with HIV/AIDS. The Care Coordinator Program helps provide appropriate quality care and services in a timely manner to people living with HIV/AIDS. The goal of the program is to help program participants become self-sufficient.

/2012/The state HIV/AIDS program focuses on the human disparities of this epidemic and is aggressively working on identifying and assisting targeted emergent communities and the minority population statewide. In 2010 KY was recognized nationally for successfully eliminating the HIV/AIDS drug waiting list.//2012//

STD PROGRAMS
STD services are provided at LHDs across the state. The primary goal of the KY Sexually Transmitted Disease/Human Immunodeficiency Virus Counseling and Testing (STD/HIVCT) program is to prevent the spread and resulting effects of sexually transmitted diseases, including HIV infection.

WOMEN'S CANCER SCREENING PROGRAM
The KY Women's Cancer Screening Program provides breast and cervical screening and follow-up services, professional education, public education, outreach, quality assurance and surveillance. Screening and follow-up services are provided from local health care providers through contracts with LHDs. The program is funded by state and federal funds and is part of the National Breast and Cervical Cancer Early Detection Program.

ACCESS TO CARE
LHDs serve as part of the healthcare safety net for those who do not have public or private insurance coverage or the resources to pay. Title V funding to all LHDs supports these services in part. However, there are other safety net providers for primary health care, including FQHC's and Primary Care centers.

KY's predominately rural areas contain almost 50% of KY's population and 98 of its 120 counties are non-metropolitan making successful health care recruitment to this population particularly important for the health of the state. Access issues are still a problem for many families due to poverty, transportation issues and cultural isolation. Of the 120 counties in KY, most of the Health Professional Shortage Areas (HPSA's) are based on the county as the service area. Only thirteen

of KY's 120 do not have either a HPSA (of any discipline) or Medically Underserved Area/Population designation. Currently there are 87 counties designated wholly or partially a Medically Underserved Area or Population. 79 of our 120 counties are Mental Health Professional Shortage Areas, and 20 counties are currently designated Dental HPSA. The shortage area designations provide the counties with an opportunity for better recruitment and retention of providers through programs such as the National Health Service Corps and J1 Visa Waiver Programs. The designations enable the county to participate in Rural Health Clinic Programs and Federally Qualified Health Center (FQHC) Programs that serve the low income and uninsured.

The KY Primary Care Association is a private, non-profit corporation of community health centers, rural health clinics, primary care centers and other organizations and individuals concerned about access to health care services for the state's underserved rural and urban populations. There are currently 18 Section 330 Health Centers operating in KY that receive funding to help offset some of the cost to provide health care to low income uninsured patients. There are approximately 58 service locations including a mobile van in 35 underserved counties of the state. The importance of primary care is widely recognized and primary care centers cover all of the life stages - prenatal, pediatric, adolescent, adult and geriatric. In addition to offering primary care services, other services offered include: Dental, Mental Health/Substance Abuse, OB/GYN, Pharmacy, Other Professional Services and Specialty Care. In 2005, 224,183 individuals received services in the primary care centers. Three centers focus their services toward the homeless and seasonal/migrants farm workers.

2012/Only 12 of KY's 120 do not have a HPSA (of any discipline) or Medically Underserved Area/Population designation. Currently there are 89 counties designated wholly or partially a Medically Underserved Area or Population. 65 counties are designated, wholly or in part, an Area or Population HPSA. 80 of our 120 counties are Mental Health Professional Shortage Areas, and 31 counties are currently designated Dental HPSA. In 2010, approximately 267,000 individuals received services in the Primary Care Centers.//2012//

/2013/ In 2010, approximately 275,169 individuals received services in the primary care centers with over 1 million patient visits. In 2011 eleven (11) of KY's counties have neither a HPSA or Medically Underserved Area/Population designation. Currently there are 91 counties designated as Medically Underserved Areas or Populations. 79 counties are Mental Health Professional Shortage Areas, and 31 counties are designated Dental HPSA. //2013//

The UK Center for Excellence in Rural Health in Hazard is one of the FQHC's and was established in 1990 to address health disparities in rural KY, including a chronic shortage of health professionals and resident's poor health status. The center accomplishes this through health professions education, health policy research, health care service and community engagement. Nearly 80% of the center's graduates are practicing in rural areas, most of them in KY. The center houses the North Fork Valley Community Health Center, the host clinic for the East KY Family Medicine Residency Program. The center also houses the KY Homeplace program and KY State Office of Rural Health, which are nationally recognized for improving rural residents' access to health care.

MCH's Oral Health Program partially funds and supports UK's College of Dentistry Outreach Dental Program in their Public Health Dentistry Department. This funding allows UKCD to take preventive and restorative services to the more underserved areas of KY through their mobile dental vans and free-standing clinics in Madisonville, Hazard, and Morehead.

The UK College of Medicine began a The Rural Physicians Leadership track to train medical students to work in rural communities. Students spend 2 years at the medical college in Lexington and 2 years at Morehead State University in Eastern KY. In addition to the medical school curriculum, students learn business skills needed to establish a medical practice in a rural setting. In addition, the UK College of Medicine partnered with the UK Dental School to develop a

network of rural centers for a translational research network, enhancing the capacity and access to dental care and other services in areas where there is little available. University of Louisville partnered with Trover Clinic in western KY and offers medical students in the third and fourth year clinical rotations in a rural program. Both universities are funded from DPH for Area Health Education Centers, which provide health education for providers, and assist in placing students with private providers for rural health rotations.

HEALTH DISPARITIES

The KY Office of Health Equity (KY OHE) was established in September 2008, operating through the DPH Commissioner's Office. Funding from the U.S. Department of Health and Human Services (US DHHS), Office of Minority Health (OMH) supports KY OHE. The office was created to address health disparities among racial and ethnic minorities, and rural Appalachian populations. Specifically, KY OHE seeks to create opportunities for health equity relating to infant mortality and preconception care as well as chronic diseases such as cancer, diabetes, heart disease, and HIV.

The goals of the KY OHE are: build the state's infrastructure to address the elimination of health disparities through strategic planning, data collection, and program evaluation; train and develop a culturally competent public health workforce across the state of KY; disseminate culturally and linguistically appropriate products, health programs and health services; enhance community capacity to develop health equity; support policies for the elimination of health disparities.

The KY OHE supports a wide variety of activities and services including promoting effective partnerships with local universities, non-profit organizations, and private health systems. Since 2008, KY OHE formed official partnerships with many agencies to strengthen prevention in relation to minority health.

The Jefferson County Infant Mortality Project was developed in collaboration with the Center for Health Equity, based out of the Louisville Metro DPH and Wellness with the purpose to determine the socio-ecological influences/social determinants that lead to adverse pregnancy outcomes and infant mortality among African-American women in urban communities of Jefferson County. Focus groups were conducted and the results are being analyzed. The Louisville Metro Health Department (LMHD) Healthy Start (HS) Program is federally funded and is an initiative mandated to reduce the rate of infant mortality and improve perinatal outcomes through grants to areas with high annual rates of infant mortality.

The Bluegrass Farm worker Health Clinic (BFHC) provides services to the ever growing Hispanic population of seasonal migrant workers. The Center consists of two facilities to serve migrant and seasonal farm workers in Madison, Fayette, Garrard, Jessamine, Woodford, Bourbon, Clark and Scott counties. All staff members are bilingual. The Center provides preventative care, such as family planning, TB screenings and blood pressure checks, and health education.

COMMISSION FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CCSHCN)

CCSHCN dates back to 1924 when it was created by the State Legislature in response to a request from the Rotary Club to provide treatment to children with orthopedic conditions through itinerant clinics across the state. The focus on community-based systems of care continues today. In addition to being a direct services provider, CCSHCN assumes a leadership role in assuring state and local systems of care for children and youth with special health care needs (CYSHCN) and in promoting a broader definition of health for CYSHCN and their families as defined by the World Health Organization: "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

CCSHCN has a strong commitment to the inclusion of families and family support. This was acknowledged and enhanced in 2009, when CCSHCN was awarded the Family to Family Grant Health Information Center grant, which provides for developing family partnerships throughout the

state, so families may act as mentors for each other. As a national leader in developing systems to support the transition of CYSHCN to adulthood, KY became the first state to develop a Title V performance measure for transition to adulthood in 1997. This initiative has continued to be an area of growth and continues to evolve to meet the needs of our children beginning at enrollment, regardless of age.

CCSHCN focuses on the expanded need to serve children statewide, with an increased emphasis on population-based services. The KY Early Hearing Detection and Intervention (EHDI) program consistently reports the screening of over 99% of KY newborns with referrals for diagnostic screening given to all children reported to have a risk factor for hearing loss. The program is currently focused on obtaining the follow-up diagnostic testing results for the newborns who have been identified as at-risk for hearing loss.

/2012/During the past year, CCSHCN has initiated a thorough examination of the agency's policies and procedures manual in an effort to align to the current environment. Each policy is being reviewed with an eye towards process improvement and better definition of the role and interactions with community partners. Several new practices are either proposed or now in effect, most notably the agency's State Performance Measures - obesity and transitions; more information follows in the narrative for SPMs 7 & 8.//2012//

/2013/ As of 11/1/11, KY moved forward with a new network of 3 statewide Medicaid managed care organizations (MCOs), in addition to the 1 MCO already in place in the Louisville area. In an effort to save state funds, the project was implemented at a significantly accelerated pace. This caused access to care issues, as CYSHCN and their families were suddenly faced with navigating an unfamiliar system of managed care. While families now have choices in coverage among the 3 MCOs, finding contracted providers to meet their needs has been a challenge. Providers are upset about payment issues, which may result in provider networks being less robust. Pre-authorizations for medical procedures for which CCSHCN had previously been exempted is also an issue. Due to the large percentage (37.6%) of CYSHCN on Medicaid or KCHIP in our state, this presents an obstacle and is a tumultuous time for this program.

CCSHCN's foster care support programs continue to remain a vital component of KY's plan to meet the health care needs of children in the child welfare system. Co-located nurse consultants provide consultation to and medical coordination assistance for the child welfare personnel; agency nurses provide home visitation services to medically fragile children in foster care, and CCSHCN and UK jointly operate a medical home clinic operating to serve the needs of both children in foster care and low-income children. These programs predated the federal Fostering Connections to Success Act, and aimed to address system failures in service gaps/fragmentation/duplication. The focus at this time is on data and accountability. Quantifying that the collaboration is a success is a goal, continuing what works, and refining what may need improvement, expanding where appropriate.

CCSHCN intends to expand services beyond the relatively small population of CYSHCN traditionally served by the program. During the process of applying for State Implementation Grant/D70 funding, CCSHCN looked at the system of care, particularly with an eye towards improving transition to adult health care providers and assurance of medical home-type environments. Although the life span of CYSHCN continues to increase, adult providers remain unfamiliar with the pediatric histories of CYSHCN presenting as new patients. CCSHCN has been educating CYSHCN but notes a disconnect between what a youth may know and what he/she executes, for various reasons. CCSHCN continues to partner with youths to empower them to manage their own care from youth to adulthood. While continuing to educate about overcoming barriers, CCSHCN also aims to assist in providers' ability to receive the CYSHCN. CCSHCN's effort to span the gap includes efforts such as the SIG/D70 grant, and the agency's 13-point Transition Action

Plan (see SPM 8).

The State Implementation Grant/D70 partnership has convened a steering committee comprised of internal and external stakeholders and representatives from professional groups and families to direct the activities of the grant. Further, CCSHCN is participating in discussions with several of KY's primary stakeholders to collaborate on the delivery of health care in a more community-based system of itinerant clinics. There seems to be a philosophical shift among public and private entities toward community-based care and recruitment/retention of medical specialists.

CCSHCN is in the process of strategic planning to guide vision and direction for the next 3-5 years. //2013//

B. Agency Capacity

Assurance for the Health of Kentucky's Women, Infants and Children

Capacity - Policy

Governor Steve Beshear and the First Lady have been actively promoting child health in KY. Together with statewide providers, DPH supported the Governor's initiative by working to help increase the enrollment of eligible families in KCHIP and Medicaid by more than 41,795 children by April 2010, exceeding 19% the original target of adding 35,000 children. LHDs identify potentially eligible families and partner with community providers, schools and agencies to offer families help with a streamlined enrollment process. In addition, the Governor has established two Task Forces. The Task Force on Early Childhood Education and Care is reviewing the state's current early childhood programs and will make recommendations to enhance or expand them, or identify gaps to fill. The Task Force on Philanthropy is to focus the state's philanthropic groups on a few worthy causes that could have more impact with a combined effort of support. MCH programs have been presented to both groups and were well received. The Governor has also adopted Children's Oral Health as one of his initiatives, and toured the state with the State Dental Director announcing the HRSA Oral Health Grant and the awarding of the 24 Oral Health Coalitions through grant funding.

/2012/Since April, 2010, an additional 13,544 children have been enrolled in KCHIP.//2012//

In the 2000 KY Legislative Session, the "KIDS NOW" Early Childhood Development Authority was created to administer tobacco settlement money to support programs for children from the prenatal period through age 5. This program added $25 million to early childhood programs, as well as a system of accountability and collaboration for early childhood systems in KY. Although receipts from the Master Tobacco Settlement (MTS) are down from decreased tobacco sales, KY has maintained their commitment to dedicate this portion of MTS dollars to invest in children. The KY Medicaid program has also maintained its commitment to KY's women and children despite challenging financial times. Eligibility for services for pregnant women and children remains at a high level and eligibility and enrollment have not been curtailed as a cost-cutting strategy. The commitment to KCHIP also remains firm.

/2013/ Early Childhood remains a major policy push of this Governor. The Early Childhood Task Force and Early Childhood Development Authority have been re-designed and re-purposed to become the Early Childhood Advisory Council required by the Head Start Re-authorization, and is housed in the Governor's Office of Early Childhood. Major initiatives include a universal kindergarten screener and work towards a comprehensive early childhood data system.

A number of public-private partnerships and foundations work to explore and address health policy issues in KY. These include the KY Institute of Medicine, based at UK, the

Foundation for a Healthy Kentucky, The Freidel Committee for Health Care Transformation, and the Child Healthy Policy Center at Cincinnati Children's Hospital. Professional organizations, especially the KY AAP, KY ACOG, and the Kentucky Medical Association, are actively involved in health care policy development. The KY Public Health Association and Kentucky Health Department Director's Association develop policy statements specifically around public health in the state. //2013//

Capacity - Kentucky Statutes
State statutes relevant to Title V programs are listed below and may be viewed in their entirety at http://lrc.ky.gov.

Perinatal & Women's Health

KRS 194A.095 Directs that an Office of Women's Health be established within the Cabinet for Health and Family Services.

KRS 214.160 Requires syphilis testing for pregnant women.

KRS 211.651 - KRS 211.670 Authorizes the Birth Surveillance Registry administered by the Division of Adult and Child Health Improvement. Allows Birth Surveillance Registry personnel to review and receive records from medical laboratories and general acute-care hospital if voluntarily participating in keeping a listing of both inpatients and outpatients.

KRS 214.155 Authorizes newborn screening for inborn errors of metabolism and other hereditary disorders. This regulation is currently being revised to reflect the expanded newborn screening legislation that was passed in the 2005 Kentucky General Assembly.

KRS 304.17A-139 Provides for a $ 25,000 cap on coverage for inherited metabolic diseases nonmedical formulas and a separate cap of $ 4,000 on low-protein modified foods for each plan year.

KRS 311.6526 Requires guidelines for responding to abandoned infants, including preserving the confidentiality of the parent, and define "newborn infant" as an infant less than seventy-two (72) hours old. Providing implied consent for treatment and confidentiality for the person releasing the infant with the provision unless indicators of child abuse or neglect are present.

HB 108 AN ACT relating to the protection of unborn children. Created a new section of KRS Chapter 507 to include unborn child after viability within the definition of "person" for the purposes of the criminal homicide statues to criminalize fetal homicide; create a new section of KRS Chapter 532 to provide a sentence enhancement for criminally causing a miscarriage or still birth of a fetus before viability.

Pediatric

KRS 156.501 Established a full-time position of education school nurse consultant within the Department of Education and specify employment requirements and job duties to include development of protocols for health procedures, quality improvement measures for schools and local health departments and data collection and reporting.

KRS 200.650-KRS 200.676 Kentucky Early Intervention System/ First Steps.

KRS 211.680 Authorizes the Department for Public Health to coordinate efforts to reduce the number of child fatalities through reviews of unexpected child deaths.

KRS 211.900-KRS 211.905 Authorizes comprehensive lead poisoning prevention services.

KRS 214.034-KRS 214.036 Establishes immunization requirements for children.

KRS 214.185 Permits diagnosis and treatment of minors for contraception, sexually transmitted diseases and pregnancy related care without parental consent.

KRS Chapter 95A.200 Establishes a Safety Education Fund to be administered by the Commission on Fire Protection Personnel Standards and Education to initiate education programs in the public schools and other agencies to reduce and prevent injuries and loss of life.

Children with Special Health Care Needs

KRS 194A.030(7) Creates the Commission for Children with Special Health Care Needs

KRS 200.460 - KRS 200.499 Commission for Children with Special Health Care Needs. Establishes the organization and guidelines for providing services to children with special health care needs.

KRS 200.550 - KRS 200.560 Provides for the detection and treatment of children and adults with bleeding disorders.

KRS 211.645, 211.647 and 216.2970 Universal Newborn Hearing Screening.

KRS 213.046 When a birth certificate is filed for any birth that occurred outside an institution, the Cabinet for Health and Family Services shall forward information regarding the need for an auditory screening for an infant and a list of options available for obtaining an auditory screening for an infant.

911 KAR 1:070. (Formerly 902 KAR 4:070) Implements the services of the Commission for Children with Special Health Care Needs.

MCH General

KRS 211.180 Gives the Department for Public Health the responsibility for public health, including improving the health of mothers, infants and children.

HB 67 Allows ARNPs and RNS to distribute nonscheduled legend drugs from a Department for Public Health approved list in local health departments.

2010 Legislation

Five bills passed both legislative chambers and have been signed into law by Governor Beshear, in 2010 that have particular relevance for our maternal and child health population.

HB 51 Requires the Cabinet for Health and Family Services to post suicide prevention awareness and training information on its Web page by August 1, 2010. It also requires every public middle and high school administrator to disseminate suicide prevention awareness information to all middle and high school students by September 1, 2010, and September 1 of each year thereafter.

HB 159 Establishes new sections related to the practice of applied behavior analysis. Key features of the law include establishment of a license for applied behavior analysis practitioners and coverage by insurance for applied behavior analysis services for individuals with autism spectrum disorders. While mandated insurance coverage is substantial, there is little impact on the First Steps Program as this law specifies that applied behavior analysis services do not replace or otherwise affect the obligation to provide services under an individualized service plan. Insurance coverage for these services is in addition to services entitled under a publicly funded

program.

HB 179 Includes revisions to the Dental Practice Act that will increase dental services in Kentucky's local health departments. The "Public Health Dental Hygienist" is a newly established category of hygiene licensure that limits the employment of this professional to public health but expands the scope of services they can provide without the presence of a licensed dentist. The new scope of practice includes the services now being provided by our public health nurses, but will now also include the placement of dental sealants.

HB 285 Is intended to help law enforcement officers, health care professionals, inmates, day care workers, and others who work with children to improve their abilities to spot signs of pediatric abusive head trauma.

HB 415 Includes provisions to prohibit text messaging, instant messaging, and e-mailing while operating a motor vehicle. It also prohibits cell phone use while driving if the driver is under eighteen years of age.

/2012/2011 Legislation
During the 2011 General Assembly, House Concurrent Resolution (HCR) 13 was passed by both chambers and sent to the Governor. Governor Beshear signed HCR 13 which establishes the Legislative Task Force on Childhood Obesity. The task force shall submit a report of its recommendations to the Legislative Research Commission and the Interim Joint Committee on Health and Welfare by November 30, 2011. Other bills regarding obesity that did not pass both chambers addressed: nutrition and physical activity standards in childcare agencies, increasing the time for physical activity in schools with kindergarten through grade 5, and reporting body mass index (BMI) on school physical examination forms.

Three other noteworthy pieces of legislation that were introduced but not passed addressed: educating parents and caregivers about pediatric abusive head trauma, prohibiting smoking in all public places and places of employment, and prohibiting smoking in vehicles used for transporting children.

While most of the bills mentioned above were not signed into law, we are pleased that the public debate on these important issues will continue.//2012//

/2013/ The successful passage of SB 110 encourages schools to open their facilities to the community by extending the same protections from liability that they have during the school day if someone gets hurt while on school property after school hours. This should ultimately help reduce obesity by providing community members with more places to exercise. The passage of SB 213 allows foster care youth at age 18 to have a full year to decide whether to stay in the care of the state until they turn 21. Many foster care youth felt the previous period of six months was not enough time to make this crucial life decision. While a bill to revamp the process for reviewing child deaths and near deaths as a result of abuse and neglect did not pass, $21,000,000 was added to the state budget to hire 300 additional state social workers. This will reduce the size of caseloads which should help caseworkers work more effectively to reduce child deaths and near deaths due to abuse and neglect. //2013//

Capacity - Division of Maternal & Child Health (MCH)

The Division of MCH oversees the implementation of public health services to MCH populations in all levels of the MCH pyramid. MCH program collaborations with other state agencies is described in Section E. MCH epidemiologist and SSDI coordinator are at the division office level and epi capacity is imbedded in each of the branches. The division is comprised of three branches; Early Childhood Development, Nutrition Services, and Child & Family Health Improvement.

Early Childhood Development (ECD) Branch
The ECD Branch provides active leadership in achieving the health goals of the state's early childhood initiatives and implements statewide services for preventive health in very young children, education to the caretakers of those very young children and direct interventions for the children identified as needing developmental and/or social and emotional services. This branch promotes coordination and collaboration between the three major-birth-to-age-three programs in the state for both children with and without developmental concerns.

ECD Branch has a health policy specialist to provide epidemiology support, and three program sections: Early Childhood Promotion, Early Childhood Intervention, and Newborn Screening & Genetics Services. The Early Childhood Promotion Section includes the the Early Childhood Comprehensive Systems HRSA grant and three initiatives that were created in regulation by the early childhood legislation, KIDS NOW: HANDS, Childcare Health Consultation, and Early Childhood Mental Health. The Early Childhood Intervention Section includes the First Steps program, Kentucky's Early Intervention System (Part C) for children birth to age three who have developmental delay. The Part C program serves about 11,000 children annually. The Newborn Screening & Genetics Services section is home for the Newborn Metabolic Screening Program, Metabolic Foods and Formula program, Genetics Services and the Kentucky Birth Surveillance Registry.

Child and Family Health Improvement Branch (CFHI)
CFHI administers the Title V MCH Block Grant, and also contains many of the traditional MCH programs, with three main sections: Perinatal Health, the Oral Health Section and the Pediatric Section. The Perinatal section oversees the Prenatal Program, FIMR, and the KY Folic Acid Partnership. The Pediatrics Section includes child preventive health screenings (Well Child and EPSDT), School Health, Child Lead Poisoning Prevention, Child Fatality Review and Injury Prevention program, the Coordinated School Health Initiatives, and EPSDT & KCHIP Outreach. CFHI assures quality programs in all areas of MCH programming and policy through coordination, collaboration and technical assistance to partners throughout the state.

The Oral Health Section works continuously to make medical professionals as well as nonprofessionals aware of the linkages of oral health with general health (i.e., diabetes, heart disease, preterm low birth weight babies, early childhood caries, and others) through disease prevention and health promotion activities including fluoride varnish, dental sealants, surveillance, and mobile dental clinics. The vision is that oral health is integral to general health and most oral diseases are highly preventable using evidence-based approaches. Oral Health initiatives also target pregnant women and the links to preterm birth.

Nutrition Services Branch (NS)
The NS Branch includes the Nutrition Program, WIC Program, Breastfeeding Peer Counselor Program, and the WIC Farmers' Market Nutrition Program (FMNP), and the WIC EBT project. The federally funded WIC Program sets the standards for nutrition services. KY WIC serves about 145,000 clients per month. The program is also responsible for promoting breastfeeding.

The NS branch administers the WIC Farmers' Market Nutrition Program (FMNP). WIC FMNP provides participants in the WIC Program with food instruments/checks to purchase fresh fruits and vegetables at local farmers' markets. Fifty-two (52) local agencies/sites, approximately 14,332 WIC participants and approximately 600 farmers received the benefits of this Program.

The Medical Nutrition Therapy (MNT) program provides MNT to eligible clients in 120 counties and community nutrition education services to all counties. Each LHD must assure the services of a Registered Dietitian for referring clients who need medical nutrition therapy. Besides providing MNT to patients with problems such as obesity, diabetes and cardiovascular disease, nutritionists conduct in-service education for staff.

The KY WIC program has been innovative in moving to electronic formats for everything from vendor management to the breastfeeding peer counselors tracking and reporting. The WIC Program has received over $5.2 million for the development and piloting of an on-line, integrated EBT system. This system is currently operational in 10 counties and upon FNS approval will begin statewide rollout this year.

Capacity: Division of Women's Health (WH)

This Division of Women's Health was created in a reorganization of DPH in 2008. Dr. Connie White, and obstetrician-gynecologist and current president of KY ACOG, serves as the Division Director. This Division focuses on promotion of women's health, as well as clinical services and prevention education. Programs include the Women's Breast and Cervical Cancer program, Title X/Family Planning services including Folic Acid supplementation and counseling and Sexual Violence Prevention and Education program, Adolescent Health, Abstinence and pregnancy prevention and Positive Youth Development programs. WH is responsible for the Sexual Assault Prevention and Education Grant, partnering with the Dept for Community Based Services for its implementation. KY's Women's Cancer Screening program is one of few in the country that has met all of the CDC's 11 data indicators for the program consistently for 6 quarters. The program continues intensive outreach to women who are rarely or never screened. The division controls the Breast Cancer Trust Fund, a legislated fund for education, outreach, and research for breast cancer through sale of a breast cancer license plate and from a check-off on the KY income tax forms.The Division is also working collaboratively with the KY Commission on Women.

/2012/Joy Hoskins, RN, BSN, BA, now serves as the WH Division Director.//2012//

Capacity: Local Health Departments (LHD)

LHDs are the primary service arm of the DPH MCH programs in communities across the state. LHDs provide services in all 120 counties of the state, and are administered through 16 district health departments and 41 independent health departments. LHDs employ nearly 3700 of the MCH workforce. The majority of the Title V block grant funding, after the 34.9% that goes to CCYSHCN, goes out to the local health departments in an allocation proportional to the services they are delivering. Fund is restricted to specific MCH cost centers, but each health department can distribute their funding across those cost centers according to local needs. Standards of care are assured through DPH guidance documents, the Administrative Reference and the Public Health Practice Reference. State program staff provide oversight through trainings, quality assurance, technical assistance, and monitoring of service and billing data. Detailed elsewhere, health departments promote coordination and collaboration in their communities through outreach efforts to patients, medical homes, and other community providers, as well as participation in community partnerships such as Early Childhood Councils, District Early Intervention Committees, Partnership for a Fit Kentucky local coalitions, Oral health coalitions, Site-based school councils, Coordinated School Health, and other community-based groups. Locally and at the state level, health departments often collaborate with County Extension Agents on health education topics.

Capacity: Universities.

The MCH Program provides direct services and population based services thru the two state University Medical Centers that have comprehensive Pediatric and Women's Health programs, the UK and U of L. Through contracts with the universities, the MCH program assures subspecialty care, including Genetics, Metabolic, Developmental, and Neonatal follow up services, are available across the state. This is still for the most part accomplished through regional clinics, but alternative approaches such as telemedicine are being developed for those uses where it is appropriate. Both University medical centers provide a full range of maternal and pediatric medical and surgical subspecialists who are available for consultation with providers in local communities, and provide transport of complex patients to the universities from out in the

state when necessary.

Capacity: Commission for Children with Special Health Care Needs (CCSHCN)

Despite challenging economic times, the Commission maintains a strong commitment to enhancing the quality of life for KY's children with special health care needs through direct service, leadership, education and collaboration. Through 12 regional offices across the state, direct medical services are provided to children with defined medical conditions, both congenital and acquired. Locations of regional offices and list of conditions treated by CCSHCN can be found at: http://chfs.ky.gov/ccshcn. Through diverse staff (nurses, therapists, nutritionist, transition coordinator, social workers, medical director, audiologists, parent liaisons, for example), CCSHCN provides family-centered, community-based care by sending treatment teams including nurses and pediatric specialty physicians to clinic sites throughout the state. Clinics for specific complex conditions that require multi-physician treatment teams are held only in Bowling Green, Louisville and Lexington due to availability and coordination of providers.

Throughout the state, alignment with universities and partnerships with other agencies (e.g. Shriner's & Kosair hospitals, Norton Healthcare) support access-to-care issues, lend capacity to the agency, and promote non-duplication of services. Families in need receive financial support to assist with travel and/or lodging in order to attend clinics or receive hospital services.

CCSHCN maintains a local provider network through contracts with approximately 600 contract physicians and surgeons. Other medical and ancillary services e.g., therapists, pharmacists, audiologists are available through contracts with local community providers. CCSHCN also contracts with foreign and sign-language interpretative services to assure effective communication that is easily understood by families of diverse cultures including those with hearing impairments. These services are available in each Commission region. CCSHCN has a Memorandum of Agreement with the UK to operate and staff a Medical Home for Coordinated Pediatrics, designed to provide primary health care and other services to the foster care population. CCSHCN also has a Memorandum of Understanding with the Department for Community Based Services (DCBS) to provide nursing consultative services to children in the foster care system. Consultation to the DCBS social workers and foster care families includes discussion of medical issues, interpreting medical records and reports, assuring updated portable health summaries and enhancing care coordination of all services to improve health outcomes for this population.

CCSHCN supports and encourages process improvement with the recommendations of parents of and children and youth with special health care needs. In addition to two parent consultants who are on staff, the agency coordinates a Youth Advisory Council which provides an opportunity for children and youth with special health care needs to collaborate with other youth, discuss pertinent issues, express needs to CCSHCN staff and become empowered in the management of their own health care. As well, the Parent Advisory Council and provides the same opportunity for parents of children and youth with special health care needs. Council members are provided financial support with their travel, meals, and lodging.

In 2009, CCSHCN received a Family to Family Health Information Center (F2F) grant. This funding provides parent consultants the ability to coordinate family partnerships throughout the state. Although the partnerships will be voluntary, CCSHCN will provide financial support with travel, childcare, meals, and lodging as needed. This new family mentor-matching program will provide a gateway for information-sharing between families, and will allow them to maximize their existing community resources. CCSHCN also received a grant for the KY Infants Sound Start initiative to support the same, as well as support for the KY chapter of Hands and Voices-an organization for families and children who are deaf or hard of hearing.

CCSHCN continues to expand the capacity of its health information system to fully support the core functions of public health as relates to CYSHCN: to assure early identification and screening

leading to diagnosis, treatment, and access to community-based systems of care; to provide comprehensive care coordination with the context of the medical home; to identify and eliminate disparities in health status outcomes; and to support program accountability through the collection, analysis, and reporting of data and progress in meeting performance targets. The electronic patient data collection system (CUP) allows staff to enter patient information directly into a system designed to serve as an electronic medical record. Information pertaining to the demographic, diagnostic, treatment, medication, insurance, and transition history for each patient is maintained in a password-protected system on a secure network. This system is designed with future expansion and accommodation of agency needs in mind. Most recently, enhancements were made which enable audiological follow-up results to be electronically transferred, whereas, in the past, agency staff was manually entering each submitted follow-up report. This will improve the collection of follow-up audiological information; thus reducing the number of children who are lost to follow-up.

CCSHCN is experiencing an expansion of audiology services, and is becoming the preferred pediatric audiology specialist in the state. CCSHCN has more pediatric audiologists than any other public or private agency, provides technical assistance to and participates in partnerships with school systems, serves as a state and national consultant on EHDI issues, and is moving towards cochlear implant support services due to the absence of other providers in this arena.

/2012/Videoconferencing equipment has been procured for several offices. This offers promise in the area of telemedicine; while not realized yet, there has been some use of this technology in staffing difficult cases. CCSHCN has obtained iPads for use by SLPs with patients, as the iPad offers applications for speech and language therapy.

Incorporating an electronic provider dictation/transcription system into the existing data system is pending the purchase of a new server.

CCSHCN has added cochlear implant mapping services and hired a second Dietician to support clinical services as well as the Obesity initiative. The agency now has Dieticians serving the eastern and western regions of the state. Neurology clinics have been added in the western half of the state to meet a growing need and improve access to care.

CCSHCN and First Steps, the state's early intervention system, have entered into partnerships in the areas of interpreter services and audiology. First Steps now contracts with CCSHCN to utilize its interpreter service network, and CCSHCN is the preferred audiology provider for First Steps. These arrangements improve quality and pathways of communication for referrals, ensure more personal and consistent connections, reduce cost to a sister agency, and increase the opportunity to capture "lost to follow-up" infants/toddlers who do not pass newborn hearing screening.

In addition to the state budget reductions which decreased available state funding by 3.8%, CCSHCN has experienced a loss of $350,000 for the year due to diminishing and redistributed tobacco settlement funds.

Other issues include the restrictive nature of state contracting and its negative impact on CCSHCN's ability to expand and respond quickly using well-trained outside vendors and specialists, and the state-mandated hiring process which is overly burdensome in its requirements, resulting in delays in filling vacancies or hiring new staff.//2012//

/2013/ All CCSHCN locations now have videoconferencing equipment, which is not only decreasing travel time and expense and increasing work time, but also is used to maximize involvement and eliminate barriers to participation in the Parent Advisory, Youth Advisory, and Medical Advisory Councils.

iPads have become a vital therapy tool for CCSHCN speech-language pathologists, who incorporate many applications into therapy. Children with communication disorders

benefit from the use of creative and motivating "apps" which facilitate progress toward the child's individual treatment plan. The device is particularly useful for children who are primarily non-verbal due to physical limitations.

CCSHCN is working on wireless access and connectivity in clinics for contracted providers and parent consultants to improve the ability to get resources to families.

A server has been procured and training of physicians and staff is now being organized in an effort to implement an electronic dictation/transcription system.

As part of the State Implementation/D70 grant, and through Kosair Childrens Hospital's Bridges to the Future transition program, more staff and partners are now devoting their time and enhancing our ability to identify CYSHCN not currently served by CCSHCN.

Personnel caps and the pay structure in place in state government limits CCSHCN's capacity to hire workers. A below-market salary range and lack of cost-of-living increases makes recruitment difficult. CCSHCN has experienced extensive turnover.

Family to Family parent mentors now receive stipends for training.

Tobacco settlement funds that have been received for over 10 years which have directly supported audiologist salaries, however, they are being totally phased out by 2014. CCSHCN is looking at ways to continue to deliver services across the state. In the audiology field, CCSHCN is now partnering with universities with doctoral programs to receive and train student externs. In the Early Hearing Detection and Intervention program, screening equipment is being placed in regional early intervention point-of-entry offices and health departments in order to increase the capacity to conduct preliminary hearing screening. CCSHCN will be expanding the cochlear implant mapping program in the near future, to provide for equipment and experts in the western (Bowling Green), central (Louisville), and eastern (Hazard) areas of the state, with plans to continue expansion as the need arises.//2013//

Capacity: MCH Data Analysis and surveillance

KY's capacity for MCH epidemiologic assessment has increased substantially in the past five years by additional staff with analytic and/or epidemiologic skills. With Tracey Jewell as the senior epidemiologist for the MCH Division and Joyce Robl as SSDI Administrator and MCH Program Evaluator, other programs with epidemiologic support include Newborn Screening, the KY Birth Surveillance Registry, Oral Health, Childhood Lead, and Child Fatality Review. The MCH epidemiology team meets monthly with the MCH Director to review projects and improve approaches to data collection and analysis.

State Systems Development Initiative (SSDI):
KY is currently in year four of a five year SSDI grant period. This grant has two major goals: 1)To increase collaboration and data capacity within DPH through data linkages and data integration of selected early childhood programs; and 2)To increase maternal and child health epidemiologic and health informatics capacity within the Division of MCH for the purpose of improved surveillance and analysis of selected early childhood outcomes as well as program evaluation. Efforts in the current year have focused on the title V needs assessment, the PRAMS survey and establishing linked birth and death files. The linkage of birth and death files was accomplished using Business Objects. Unmatched files were manually reviewed using potential matches generated by Business Objects. Linked files are available from 2006 through 2009.

Utilizing funding provided by the State System Development Grant, Dr. Arne Bathke, a statistician from the University of Kentucky has also completed two trainings for MCH epidemiologists and data analysts. The two trainings that were completed were on survival analysis and regression

with a focus on logistic regression.

/2012/KY is currently in the final year of SSDI grant period. Efforts in the current year have focused on analysis of the data from the second PRAMS pilot survey and on increasing reporting sources and improving the timeliness of ascertainment of infant deaths. These enhancements will improve the data linkages between infant birth and death certificates. This information will facilitate health intervention planning for prevention activities related to infant deaths.

Two biostatistics trainings were completed during this year for data analytic staff. The topics covered included methodology for weighting of PRAMS survey data, multicollinearity and variance inflation factors in logistic regression and Poisson regression. In the remainder of the current SSDI grant, efforts will focus on linkage of live birth certificate files with KY's Early Intervention System (Part C Program) for an epidemiological study. //2012//

/2013/ KY is currently in the first year of a two year SSDI grant period. In FY12, linkage efforts will focus on 2009 First Steps participants to their live birth certificate and Women's Infants and Children (WIC) program data to the live birth certificate. A pilot Pregnancy Risk Assessment Monitoring System (PRAMS) project will be undertaken in 2013 for eight months. Biostatistics trainings will be provided to all MCH epidemiologists by Dr. Arne Bathke from the University of Kentucky. //2013//

AMCHP Data Mini-grant (2009)Training provided two days of training on cost benefit and cost effectiveness analyses, using data from our home visiting program, HANDS. The trainings were completed by Dr. Scott Hankins. Dr. Hankins is an Assistant Professor with the College of Public Health at UK. He holds a Ph.D. in Economics from the University of Florida. His research investigates factors that affect neonatal health. He currently is studying the effect of state regulations (both insurance and hospitals) on neonatal health outcomes. He also is interested in how obstetricians respond to medical malpractice lawsuits.

Pregnancy Risk Associated Monitoring System (PRAMS):
KY is not yet funded by CDC as a PRAMS state, but has been able, through March of Dimes Grant funding and a collaboration with the UK College of Public Health Repreductive Epidemology professors, complete PRAMS pilot surveys in 2008 and 2010. The report of the initial pilot is available at http://chfs.ky.gov/dph/mch/default.htm under Related Links. The collection of 2010 data just ended in the spring, and the data is currently being weighted prior to analysis.

Capacity: MCH Workforce Development

UK Graduate Certificate in MCH: Until this initiative, KY had no training programs that focused on public health expertise in maternal and child health. DPH contracted with the College of Public Health to develop and administer the MCH Certificate to increase Kentucky's capacity to address MCH performance and outcome measures. The initial goal is to set up a certificate program for current public health professionals who are working in or interested in furthering their knowledge of MCH. The MCH Graduate Certificate has two main objectives: 1)To prepare public health workers to address the multi-factorial MCH issues in KY in their workplaces by enhancing public health-related skills. 2)To provide participants with theoretical, practical, and relevant educational experiences in MCH to enhance the health and welfare of children, mothers and families. The program began in fall of 2009 and graduated its first student in June, 2010.

/2013/ Seven students graduated with the MCH Certificate in May 2012. //2013//

MCH Epidemiology Graduate Certificate: In 2009, the University of Arizona (PI) and the UK Colleges of Public Health were awarded a $900K HRSA MCH training grant over five years to develop and implement a Graduate Certificate in MCH Epidemiology. The purpose of this project is to provide graduate-level MCH Epi education to students serving rural and American

Indian/Alaskan Native populations who would otherwise be unable to access continuing education. Course content is delivered using the internet. Fifteen students from across the nation are enrolled including three students from rural Eastern Kentucky HDs and one dentist from the UK Center for Rural Health in Hazard (KY). Ten students will receive full scholarships annually and academic credits earned will be transferable for this program which is supported by HRSA T04MC16880 from the MCH Bureau, Health Resources and Services Administration. More information about this project is available at: http://mch-epitraining.arizona.edu/default.aspx or by contacting Lorie Wayne Chesnut, University of Kentucky College of Public Health at 859-218-2226.

/2013/ Now in its third year, the program has enrolled approximately eight students from KY and over 25 students nation-wide. Over half of these students are enrolled members of federally recognized tribes and/or working in tribal health agencies. //2013//

Capacity: Cultural Competence

The Cabinet for Health and Family Services which includes both DPH and the CCSHCN requires that services to clients be delivered in a culturally competent and family centered manner. Demographic data for all programs is collected so that different cultural groups can be analyzed to inform program and policy development. LHDs receive guidance to understand and address barriers to cultural differences through the Administrative Reference guide provided by DPH. Procedures are included for interpretive services and direct-care workers. Culturally isolated are included in the target populations within the state. Materials for public health programs are made available routinely in English and Spanish, as 95% of our families who need interpreters are Spanish-speaking, but other languages are available if needed. Direct service programs, such as First Steps and HANDS, have required trainings for providers on cultural competency and family-centered approaches. Specific technical assistance for dealing with visually impaired children and deaf and hard of hearing is specifically contracted in the First Steps program, and available for other programs through the Cabinet Equal Opportunity Office.

CCSHCN is seeing a growing need to provide culturally sensitive training to staff and resources to families who are limited in English proficiency (LEP). CCSHCN has an LEP coordinator who works with office staff to educate on CHFS LEP policies and guidelines.

C. Organizational Structure

III.C. Organizational Structure

Office of the Governor

Governor Steven L. Beshear took the Oath of Office in December 2007. Governor Beshear has a B.S. and a law degree from the University of Kentucky. He has served the Kentucky in the US Army Reserves, as a State Representative, Attorney General, and Lt. Governor prior to his election. His Lt. Governor, Dr. Daniel Mongiardo is an ENT surgeon from eastern Kentucky who served as a legislator prior to becoming Lt. Governor. He received his B.S. from Transylvania University and his medical degree from the University of Kentucky School of Medicine.

Cabinet for Health and Family Services (CHFS) -- Provision of Health in Kentucky

In Dec. 2003, The Cabinet for Health Services and the Cabinet for Families and Children were consolidated into a single cabinet called The Cabinet for Health and Family Services is the state government agency that administers programs to promote the mental and physical health of Kentuckians. The Cabinet includes the following agencies: Department for Public Health (DPH), Commission for Children with Special Health Care Needs, Department for Aging and Independent Living, Department for Behavioral Health, Developmental and Intellectual Disabilities, Department for Community Based Services, Department for Family Resource Centers and Volunteer

Services, Department for Income Support, Department for Medicaid Services. The Cabinet for Health and Family Services also includes following program support agencies: Governor's Office of Electronic Health Information, Office of Administrative and Technology Services, Office of Health Policy, Office of Communication and Administrative Review, Office of Human Resource Management, Office of Inspector General, Office of Legal Services, Office of Ombudsman, and Office of Policy and Budget.

Secretary Janie Miller was appointed Secretary of the Cabinet for Health and Family Services in January of 2008. Secretary Miller received her Bachelor's of Social Work from Eastern Kentucky University. Prior to appointment as Secretary for the Cabinet for Health and Family Services, she held the position of Deputy Director of Budget Review for the Legislative Research Commission (LRC), Secretary of Public Protection, Commissioner of the Department of Insurance, and Deputy Commissioner of Health Insurance.

/2013/ Secretary Janie Miller resigned from her role of Secretary of the Cabinet for Health and Family Services February 27, 2012.

Governor Beshear appointed Audrey Tayse Haynes as the new Secretary for the Cabinet of Health and Family Services effective April 16, 2012. Sec. Haynes holds a master's degree in social work from the University of Kentucky and a bachelor's degree in social work from Spalding University in Louisville. She has experience in the community mental health system, human resource development, and served as the executive director of the Kentucky Literacy Commission under Governor Wallace Wilkinson. Her prior positions include ten years as the senior vice president and chief government affairs officer of YMCA of the USA, as well as chief of staff to Tipper Gore during Vice President Al Gore's second term. Haynes also served on President Bill Clinton's senior staff as the director of the White House Office for Women's Initiatives and Outreach. Sec. Haynes worked closely with the Centers for Disease Control and Prevention, on implementing chronic disease prevention programs across the country. She also led the creation and launch of a new community leadership program (Pioneering Healthier Communities) that convenes public, private and nonprofit leaders to focus efforts on removing barriers to healthier living. //2013//

Eric Friedlander was appointed as Deputy Secretary of the Cabinet of Health and Family Services. Prior to his appointment he served as acting Commissioner of the Department for Behavioral Health, Developmental and Intellectual Disabilities, and Executive Director of the Commission for Children with Special Health Care Needs.

Department for Public Health (DPH)

Dr. William Hacker was appointed Commissioner of DPH in November of 2004. He is Board Certified in Pediatrics and a Certified Physician Executive. He received both undergraduate and medical degrees from UK. Dr. Hacker joined the DPH as a Physician Consultant in 2001 and served as Branch Manager for the Public Health Preparedness Branch since 2002, where he has headed up the department's disaster preparedness planning efforts. Prior to joining state government, Dr. Hacker's experience included almost 20 years of private pediatric practice in southeast KY, as well as serving as the Chief Medical Officer of Appalachian Regional Healthcare, Inc. He is Board Certified in Pediatrics and a Certified Physician Executive. As the chief health officer of the state, Dr. Hacker serves as a close advisor to Governor Beshear and liason with federal agencies during the natural disasters that occurred in KY in early 2009. The ice storm of 2009 was the worst wintertime natural disaster in the state's history. This was followed by flooding. Then the H1N1 response took everyone's attention. KY's disaster planning and preparation was well tested and many lessons learned; overall performance was commended by federal agencies. Dr. Hacker meets quarterly with the Deans from all the KY-based Colleges of Public Health for sharing information, projects, and ideas.

/2012/ Dr. Hacker retired effective July 31, 2011. Dr. Steve Davis was appointed acting Commissioner of DPH effective August 1, 2011. //2012//

Dr. Steve Davis was appointed Deputy Commissioner of DPH. He received his undergraduate studies at Morehead State University and his M.D. degree from UK. He practiced pediatrics in eastern KY before coming to Frankfort in 1996, where he has continued to serve tirelessly on behalf of Kentucky's women and children.

DPH is the government agency in KY responsible for developing and operating all public health programs for the people of the Commonwealth. KY Revised Statute 194.030 created DPH to "develop and operate all programs of the cabinet that provide health services and all programs for the prevention, detection, care, and treatment of physical disability, illness, and disease." Dr. Hacker says "The Department for Public Health is about 400 employees assisting 4000 Health Professionals to care for over 4 million Kentuckians and we touch their lives in some way every day."

DPH is comprised of seven divisions: The Division of Epidemiology and Health Planning, the Division of Health Protection and Safety, the Division of Lab Services, the Division of Maternal and Child Health, the Division of Prevention and Quality Improvement, the Division of Women's Health, the Division of Administration and Financial Management.

The Division of Administration and Financial Management develops and oversees the DPH's budget as well as LHD's fiscal planning, allocations and payments, and their administrative and management practices. The division also manages departmental procurement and contracts, information technology and administrative support to LHDs in all 120 counties of the Commonwealth. The division is under the direction of Rosie Miklavcic RN, BSN, MPH.

The Division of Health Protection and Safety protects Kentuckians from unsafe consumer products, lead hazards, radiation and other toxic exposure, unsanitary milk, adulterating and misbranded foods, unsanitary public facilities, and malfunctioning sewage systems. The director of the division is Guy Delius R.S.

/2012/ Guy Delius is no longer with the division. The acting director is Kathy Fowler R.S. //2012//

The Division of Epidemiology and Health Policy is responsible for communicable disease prevention (immunization, HIV, TB, STD, etc.) and control, disease surveillance and investigation, adult injury prevention and research, maintenance of vital statistics and health data, including hospital discharge data and county health profiles. This division also publishes various health planning documents including the Kentucky Public Health Improvement Plan and Healthy Kentuckians 2010. This Division is also led by a pediatrician, Dr. Kraig Humbaugh. MCH Programs work closely with this division's programs including emergency preparedness, Immunizations, HIV, Communicable disease, and vital statistics. Vital Statistics has implemented an electronic birth certificate for all birthing hospitals. As the result of collaborative efforts, screens for this data also produce the documentation for newborn metabolic screening and universal newborn hearing screening. KY is currently working on a system for electronic death certificates.

The Division of Laboratory Services provides analysis and quality control for health department laboratories and reference services to laboratories. The central lab also conducts metabolic screening for all newborns in the KY. They identify agents from communicable disease outbreaks, as well as from bioterrorism threats.

The Division of Prevention and Quality Improvement (PQI) oversees the Chronic Disease Prevention and Control, Health Care Access programs, the Quality Improvement program, department training, and the BRFSS. Dr. Regina Washington is the Division Director. She obtained her BA from Berea College, MA in Health Sciences from Eastern Kentucky University, and a DrPH from the University of Kentucky College of Public Health. Programs addressing

chronic disease are working towards a more integrated, community-based approach with the Healthy Communities Project. The Tobacco Control program is working with the MCH Coordinated School health program on 24/7 tobacco free schools. Obesity prevention is another effort that combines the work of MCH and the chronic disease program staff.

/2013/ Dr. Washington is no longer with DPH. Gary Kupchinski was named Director of PQI in October 2011. //2013//

The Division of Women's Health oversees the women's health programs and initiatives in the Department. Their focus is on adolescent, preconcpetion and interconception care, and cancer screening. The Division is described in the Capacity section of this grant. Dr. Connie White is the division director. She is a graduate of Kentucky Wesleyan College with a Bachelor of Science in Chemistry and holds a Master of Science in Toxicology, having worked as a researcher in Teratology at the National Center for Toxicological Research in Little Rock, Arkansas. She later attended medical school at UK. Dr. White completed her OB-GYN residency program at the U of L. She is board certified in OB/GYN by the American Board of Obstetrics and Gynecology with a special emphasis of her work on patient education and preventive medical care.

/2012/Joy Hoskins, RN, BSN, BA, now serves at the Director for the Division of Women's Health. In this role, she provides administrative oversight and management of the public health services provided through the KY Women's Breast and Cervical Cancer Screening Program, the Title X Family Planning Program and the Adolescent Health/Teen Pregnancy Prevention Programs as well as other statewide initiatives which enhance the health outcomes of KY's women. She represents the Division of WH and DPH on numerous committees and coalitions, including the Cervical Cancer Free Kentucky Initiative. Mrs. Hoskins serves as the Principal Investigator for KY's Rape Prevention Education and EMPOWER II grants as well as the President of the Breast Cancer Research and Education Trust Fund. In addition to her responsibilities with the Division of WH, Mrs. Hoskins is the Assistant Director of Nursing for the DPH. In this role, she provides technical assistance and guidance regarding public health nursing practice to LHD administration and collaborates with public health leadership to support public health nurse professional development and continuing education opportunities. //2012//

The Division of Maternal and Child Health (MCH) promotes maternal, child and family health by developing systems of care and by promoting and providing preventive health services to at risk populations. The division has 3 branches including Nutrition Services, Early Childhood Development and Child & Family Health. These are described in the Capacity section. This division, through the MCH Title V grant and other activities, seeks to provide leadership, in partnership with key stakeholders, to improve the physical, socio-emotional, safety and well-being of the maternal and child health population that includes all of KY's women, infants, children, adolescents and their families. The mission is carried out in collaboration with partner agencies, primarily, local health departments, other state agencies and state universities to increase capacity for clinical and community-based services for the MCH population. At the state level, MCH goals are achieved through policy and program development, special grants, surveillance, consultation, technical assistance, education, training and case management.

Commission for Children with Special Health Care Needs (CCSHCN)

CCSHCN operates under a streamlined organizational structure, pursuant to a 2009 reorganization. The agency employs an Executive Director; a, Medical Director; 2 Division Directors with one Assistant Director; and a full administrative, support, clinical, and augmentative staff throughout 12 regional offices.

The Division of Administrative Services provides intake, personnel, provider contracting, billing, financial reporting, and health information services. The Division of Clinical and Augmentative Services provides nursing and foster care support services, including clinical operations. This division is organized in an East-West structure for clinical programs, and all therapeutic,

transition, parent consultant, and audiology services through the Early Hearing Detection and Intervention program are organized under separate managers.

CCSHCN's Executive Director and Division Directors are appointed by the Governor, as are members of the Board of Commissioners and the Hemophilia Advisory Committee - who are stakeholders and interested community members and professionals. The Board of Commissioners provides oversight and approval of the Executive Director's actions. The Board meets quarterly with the Executive Director and senior management to review program status, consult and advise on programmatic concerns, and take voting action as required. The Medical Director recruits and recommends physicians to serve in clinics and on the Medical Advisory Committee, and the Executive Director, with approval of the Board of Commissioners, appoints members to the Medical Advisory Committee. The Early Hearing Detection and Intervention (EHDI) program also operates under the oversight of the EHDI Advisory Board.

In addition to two contracted parent consultants, the agency incorporates public parent and youth involvement in decisions that impact programs and service delivery. The Parent Advisory Council and Youth Advisory Council are comprised of individuals throughout the state (not just families with children enrolled in CCSHCN services) who hold an interest in children and youths with special health care needs (CYSHCN). Each Council meets quarterly at CCSHCN's Louisville office (or via videoconference) to discuss pertinent issues, provide training and give input on how CCSHCN can better serve Kentucky families with CYSHCN.

/2013/ After a transitional year without a full-time Executive Director, Gov. Beshear appointed Jackie Richardson to lead CCSHCN from 9/1/11.//2013//

/2013/ An attachment is included in this section. DPH, and specifically the MCH Division, experienced many vacancies related to the time of year and expected turnover. A contributing factor is that additional steps have been added to the Cabinet's request process for Federally Funded employees. Requests must be reviewed by the Governor's office, incurring additional time. //2013//
An attachment is included in this section. IIIC - Organizational Structure

D. Other MCH Capacity

The KY MCH Division provides leadership to improve the physical, socio-emotional health, safety, and well-being of the maternal and child health population which includes KY's women, infants, children, adolescents, and their families. This is carried out in collaboration with partner agencies, primarily local health departments, other state agencies, and state universities. Staff support clinical and community-based services and infrastructure building through policy development and implementation, research, surveillance activities, technical assistance, consultation, training, education and case management. Staff also provide oversight to the services and activities that focus on the protection and improvement of the health of expectant mothers, infants, preschool, and school age children.

Senior Management

Director, Division of Maternal and Child Health Services (MCH)

Dr. Ruth Ann Shepherd was appointed Director of the Division of MCH on September 1, 2005. She received her B.A. from Asbury College,Wilmore, KY, and her M.D. degree from the University of Louisville School of Medicine. Dr. Shepherd did her residency in Pediatrics at Methodist Hospital Graduate Medical Center in Indianapolis, IN and her Neonatology Fellowship at Medical University of South Carolina in Charleston. Dr. Shepherd is Board Certified in Pediatrics and Neonatal-Perinatal Medicine, and has been a Certified Professional in Healthcare Quality. Her experience includes private practice in Louisville (KY), followed by 16 years as Director of Neonatology Services at Pikeville Methodist Hospital, a Regional Neonatal Intensive

Care Unit in Appalachia. She is on the Boards of the Greater Kentucky Chapter March of Dimes and the Kentucky Perinatal Association. Dr. Shepherd has presented on behalf of Kentucky at the American Public Health Association, National Center for Health Statistics, NIH MCH Education Committee, and the Surgeon General's Conference on Preterm Birth. She is served on the National Quality Forum Steering Committee for Perinatal Indicators.

/2013/ Dr. Shepherd is serving on the HHS Secretary's Advisory Committee on Infant Mortality and as co-lead of a HRSA IM COIN. She was presented the Inaugural Award for Excellence in State MCH Leadership by AMCHP. //2013//

Assistant Director, Division of MCH

Marvin Miller, MSW, is the Assistant Director for the Division. Mr. Miller has worked in public health for over thirty years, and has been assistant director in MCH for over 20 years. Mr. Miller has been instrumental in the development of the WIC program, Well Child Program, and others. A few of his accomplishments include the establishment of EPSDT outreach, a child safety seat program, and the HANDS home visiting program. Some of Mr. Miller's current functions include legislative liaison for the Division, and oversight of the LHD's plan and budget process.

Branch Manager, Child and Family Health Improvement (CFHI) Branch

Shelley Adams, MSN, RN, became the Branch Manager of CFHI on March 1, 2009. Ms. Adams came to Public Health from the Department for Medicaid Services after 4 years working primarily with community mental health and waiver programs as a Nurse Consultant Inspector, then as a branch manager in Community Alternatives. Ms. Adams has a Bachelor of Science in Nursing from Northeast Louisiana University and a Master of Science in Nursing from the University of Phoenix. Ms. Adams is the Authorizing Official of the MCH Block Grant and oversees the Prenatal, Pediatric, and Oral Health Programs.

Branch Manager, Nutrition Services Branch

Frances M. Hawkins manages the Nutrition Services Branch. Ms. Hawkins coordinates the branch, which administers the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), the Adult and Child Health (ACH) Nutrition Program, the Fruit and Veggies More Matters Program, the Breastfeeding Peer Counselor Program, the WIC Farmers' Market Nutrition Program (FMNP). Ms. Hawkins received her training at Indiana University of Pennsylvania and her Master's degree at the University of Kentucky. She has managed the Nutrition Services Branch since 1996 and is a registered, licensed dietitian.

Branch Manager, Early Childhood Development Branch (ECD)

Sandy Fawbush, RN, BSN is the ECD Branch Manager. She oversees many of the birth to three public health programs, including HANDS, First Steps and newborn screening. Ms Fawbush has been the database manager and coordinator of medical records abstraction for the Kentucky Birth Surveillance Registry for over 9 years, and led the development of KY's expanded newborn screening case mangement program. She has 25 years of nursing experience and worked on system wide quality assurance and control issues in Kentucky hospitals and chains. Ms. Fawbush has trained with Columbia HCA on coding compliance, and has experience in hospital data systems and their reporting capabilities.

Branch Manager, Health Promotions Branch

In 2011, the Health Promotions Branch became part of the MCH Division. Irene Centers, BA, is the Branch Manager, overseeing Healthy Communities, Tobacco Prevention and Cessation, and Obesity programs. Ms. Centers holds a degree from Morehead State University in Health, Physical Education, and Recreation. Prior to June 2012, Ms Centers led the state Tobacco

Prevention and Cessation Program for eleven years where she was responsible for the leadership role in national, state and local tobacco control initiatives. As Program Manager, she reported to legislative and statutory committees that oversee programs funded by Kentucky's Master Settlement Agreement, administers federal grants and state MSA funds related to tobacco use.

Director, Division of Women's Health (WH)

Connie Gayle White M.D. was appointed the Director of the Division of WH in March, 2009, joining the division after practicing obstetrician/gynecologist for over 20 years in Frankfort, Kentucky. She is a graduate of Kentucky Wesleyan College with a Bachelor of Science in Chemistry. She received a Master of Science in Toxicology and worked as a researcher in Teratology at the National Center for Toxicological Research in Little Rock, Arkansas. She later attended medical school at the University of Kentucky. She completed her OB-GYN residency program at the University of Louisville. She is board certified in OB/GYN with a special emphasis of her work on patient education and preventive medical care. Dr. White's professional activities include the Board of Trustees Frankfort Regional Medical Center (chair 2007-2008), American Congress of OB/GYN (ACOG), and ACOG Kentucky Section (Chair 2007-2010, Vice President 2006, Secretary/Treasurer 2004-2006). She has been active on the Planned Parenthood of the Bluegrass Board of Directors, Frankfort United Way, Frankfort Arts Foundation and Medicaid Therapeutics Advisory Committee. Dr. White currently serves on the KY Cancer Consortium Advisory Board, the KY Colon Cancer Advisory Board, and is a member of the KY Perinatal Association. She is also the current President of the Breast Cancer Education and Research Trust Fund.

/2012/Dr. White is no longer with the division. Joy Hoskins, RN, BSN, BA now serves as the Director. Ms. Hoskins, graduated in 1981 from the University of Kentucky with a BA degree in Communications. She graduated in 1995 with her ADN degree from Midway College where she received the President's Award for outstanding nursing graduate in the associate's degree program. After graduation, Joy was employed by the Frankfort Regional Medical Center. In 1999, Joy transferred to the Cabinet for Health and Family Services where she worked for the Department for Medicaid Services for nearly two years where she managed 20 nurses and provided the management and oversight of the enrollment of nearly 63,000 Medicaid beneficiaries into the managed care program. She has been with DPH since 2000 with most of her experience served with maternal and child health programs and women's health programs, including the childhood lead poisoning prevention program, the Title X program director, the adolescent health program coordinator and program director for the Kentucky Women's Cancer Screening program. In 2008, Joy accepted a new role as the Assistant Director of Nursing for DPH. She has served as the division director of WH since August, 2010. In December, 2010, Joy graduated with her BSN degree from Kentucky State University where she received the Dr. Juanita W. Fleming Excellence Award presented to the BSN student who exhibited academic excellent, leadership and commitment to practice.//2012//

Title V Administrator

/2013/ The Title V Administrator position has been merged with the Branch Manager position. Shelley Adams continues as the Title V Administrator and Branch Manager of Child and Family Health Improvement. //2013//

State Dental Director

Julie McKee, DMD was named the State Dental Director in September 2007. Dr. McKee has a BS in Biology from the University of Kentucky and her DMD from the University of Louisville. Prior to her appointment, Dr. McKee was the Director of the WEDCO District Health Department for more than 12 years. Dr. McKee has been instrumental in expanding the Kentucky Oral Health Program to serve citizens of Kentucky and has successfully secured major HRSA and

Appalachian Regional Commission grants to work toward increasing dental services for children in the state.

MCH Epidemiologist

Tracey D. Jewell, MPH is the lead maternal and child epidemiologist for the MCH Division. Ms. Jewell earned her Master of Public Health degree at the University of Alabama Birmingham, School of Public Health in 1998. She joined the staff at the DPH in February of 1999 and came to the MCH Division in January of 2001 to assume her present position. Effective September 1, 2005, Ms. Jewell was promoted to Lead Epidemiologist for the Division of Maternal and Child Health. Ms. Jewell is involved in all MCH epidemiology efforts.

Director, Office of Health Equity (OHE)

Torrie T. Harris is an Assistant Professor in Health Systems Management at UK. Dr. Harris was recruited to be Director at the OHE for the Kentucky DPH. She received her Dr.P.H. from the University of Kentucky, College of Public Health in Health Behavior.

/2012/ Additions to the OHE include: Vivian Lasley-Bibbs, MPH as the new Health Disparities Epidemiologist and Healthy People 2020 State Coordinator, and Maria Gomez who serves as the Health Equity Program Coordinator and focus primarily on Cultural and Linguistic Competency training, education, assessment, and research. She will also be responsible for working with internal and external partners to raise awareness about health disparities and assure a focus on minority and rural health issues. //2012//

/2013/ Vivian Lasley-Bibbs, MPH, is the acting director for the DPH Office of Health Equity. She is also the state epidemiologist for the Office of Health Equity, currently serving as state coordinator for Healthy People 2020. Ms. Lasley-Bibbs earned a bachelor's degree in Biology from Kentucky State University and a master's degree in Hospital and Molecular Epidemiology from the School of Public Health at the University of Michigan. She is also a graduate of the Physician Assistant Program in the UK's College of Allied Health and is currently completing her doctorate in PH with an Epidemiology concentration in the College of Public Health at UK. Her professional affiliations include national and state public health organizations, state work groups, as well as civic and community based organizations. //2013//

Commission for Children with Special Health Care Needs - Senior Management Staff

In 2008, Kentucky experienced widespread retirement as a result of a designated retirement window. The Commission for Children with Special Health Care Needs (CCSHCN) was impacted as well.

Executive Director - Rebecca Cecil, R. Ph., served as CCSHCN's Executive Director from 2008 to 2010. Ms. Cecil served as CCSHCN's Director of Health and Development immediately prior to her appointment.

Medical Director - Richard McChane, MD, has served as CCSHCN's Medical Director since March, 2007. Dr. McChane is also the Medical Director of the Home of the Innocents (a private child caring facility serving children with special needs in Louisville, serves as a developmental pediatrician at the University of Louisville Weisskopf Child Evaluation Center, and is a faculty member with the University of Louisville School of Medicine - Department of Pediatrics.

Director of the Division of Administrative Services - Shelley Meredith has served as director of this division since October 2008. Ms. Meredith has over 25 years experience with state government, over 20 of which have been with the Cabinet for Health and Family Services in the health care arena. Ms. Meredith played a key role in the establishment and development of the

CCSHCN's health information system and electronic medical record and is now responsible for managing all the operational functions of CCSHCN including budgets, contracts, purchasing, accounts payable and receivable, health information and technology, personnel, and grant reporting. Ms. Meredith is a Certified Public Accountant and 1985 graduate of the University of Kentucky with a BS in Accounting and a minor in Economics.

Director of Clinical & Augmentative Services - Anne Swinford has served as director of this division since 2005. Ms. Swinford's previous experience includes the provision of direct speech and language services to the special needs population, and serving as the Acting Part C Coordinator and supervisor of Kentucky's early intervention program (First Steps). Ms. Swinford has over 25 years experience with special needs populations, including 17 in Kentucky's Cabinet for Health and Family Services. Ms. Swinford is a graduate of Brescia University and Purdue University, where she earned a BA in Speech and Hearing and a MS in Speech Pathology.

Assistant Director of Clinical & Augmentative Services - As assistant director, Karen Rundall functions as CCSHCN's Director of Nursing. Ms. Rundall has served in this role since 2009. Ms. Rundall has over 22 years of experience as a registered nurse providing pediatric care for children with special needs, including 9 years at CCSHCN as a care coordinator and nurse service administrator. Ms. Rundall is a certified case manager (CCM) and a graduate of Jefferson Community College (ADN) and Bellarmine University (BSN), both of which have contracted with her to teach pediatric clinical experience at Kosair Children's Hospital. She also holds an MSN in Healthcare Leadership and Management from Western Governor's University.

CCSHCN Title V MCH Block Grant Coordinator - Mike Weinrauch serves as CCSHCN's Title V coordinator. Other areas of focus include technical assistance with foster care support programs, social work with the bleeding disorder population, guidance to staff on brokering community resources, and general policy analysis/program evaluation. Prior to employment with CCSHCN, Mr. Weinrauch served in KY's child welfare & adult protective services agency as a field worker and administrator at the regional and state levels. Mr. Weinrauch is a graduate of the University of Vermont (BA), the University of Kentucky (MSW), and the University of Louisville (MPA).

/2012/Effective 9/1/2010, Rebecca Cecil retired as Executive Director. The Cabinet for Health & Family Services Deputy Secretary (and previous CCSHCN Executive Director), Eric Friedlander is serving part-time as Acting Executive Director, until such time as a full-time replacement is appointed.//2012//

/2013/ Effective 9/1/2011, Jackie Richardson was appointed Executive Director. Ms. Richardson served 18 years with the Louisville Metro Government in various roles. Her career encompasses experience as an Internal Auditor, Business Manager, Chief Financial Officer and most recently 4 years serving as the Chief of Staff for the Louisville Metro Department of Public Health and Wellness. Mrs. Richardson possesses a Masters in Business Administration and a certification as a Professional in Human Resources.//2013

E. State Agency Coordination

Collaboration -- Local Health Departments (LHD)
LHDs provide services in cooperation with the Title V program in all 120 counties. These include WIC, EPSDT and Well-Child Preventative exams, Immunizations, Family Planning, Breast and Cervical Cancer Screening, HANDS Home Visiting, and many other programs. Many health departments provide EPSDT and preventative pediatric services in the school settings, improving access to these servcies for children. Currently 19 LHD's provide an in-house prenatal clinic; others assure prenatal care thru a local obstetrician medical home. Women diagnosed as pregnant through the Family Planning program, or presenting to the health department pregnant for any reason, are assisted in applying for Presumptive Eligibility for Medicaid if appropriate for their income levels. This provides coverage for 90 days while they go thru an official eligibility determination. Prenatal servcies for the uninsured are funded through an allocation from the Title

V MCH BLock grant. All LHD programs are trained to screen and refer for smoking cessation. The LHDs operate under the Kentucky Public Health Practice Reference (PHPR) standards of care for delivery of all clinical services. Data on encounter services provided is captured through a single data system, allowing for thorough review and analysis of all services rendered.
DPH has the capacity to connect with LHDs and hospitals across the state through a tele-health network. The network is used for training, state-wide educational meetings for public health nurses, and also is a method for communication during distasters or epidemics.

/2013/ LHDs have experienced financial stressors in FY11-12 from reduced funding resulting in drastic budgetary and personnel changes. DPH has worked closely with those LHDs most affected to promote positive actions to local health operatons. //2013//

Collaboration -- Department for Medicaid Services (DMS)
KenPac: The Kentucky Patient Access and Care (KenPAC) Program is a primary care case management program that increases access to primary and preventive health services and coordinates other Medicaid covered health care and related services for Medicaid members eligible to participate in the program. A pediatrician, internist, family doctor, general practitioner, OB/GYN, rural health clinic, primary care center or nurse practitioner acts as the primary care provider (PCP) for Medicaid members enrolled in KenPAC. Kentuckians who receive financial assistance through the Kentucky Transitional Assistance Program (K-TAP), [formerly Aid to Families with Dependent Children (AFDC)] and adults aged 19 and older who receive Supplemental Security Income (SSI), are enrolled in the KenPAC program. The KenPAC program has regional nurses that are located around the Commonwealth in areas with high Medicaid population densities. The KenPac care coordinators serve as a liaison between Medicaid and the KenPAC providers, and local health departments.

KCHIP: Eligibility is determined by the Dept for Community Based Services (DCBS). KCHIP children use the same health care providers as Medicaid and are served through the same service delivery systems as Medicaid. KCHIP members enrolled are required to select a Primary Care Physician (PC). PCPs or Primary Care Case Managers are responsible for the coordination of medical services for children enrolled in KCHIP. The purpose for these medical homes is to provide each child with a health care professional who understands the unique needs of the child.

/2012/ Children who have a medical home are more likely to have regular physicals and immunizations, thus encouraging the use of the emergency departments only for emergent situations. //2012//

DPH has a long history of working cooperatively with DMS. This relationship continues through several Interagency Agreements (Memorandum of Agreement or MOA) that are renewed annually. The programs included in these agreements include:
-The preventive health services delivered to Medicaid recipients by LHDs and reimbursed by the DMS.
- The early intervention services for Medicaid-eligible infants and toddlers who are determined eligible for First Steps, Kentucky's Early Intervention System, authorized by the Individuals with Disabilities Education Act and reimbursed by DMS.
- The Health Access Nurturing and Development Services Program (HANDS) for home visiting services to Medicaid-eligible pregnant women, parents and children and are reimbursed by the DMS.
- The Medicaid Services Presumptive Eligibility Program for Pregnant Women allows pregnant women to receive prenatal care through Medicaid for up to 90 days while their eligibility for full Medicaid benefits is determined.
- The Breast and Cervical Cancer Treatment program provides cancer care to women diagnosed in the DPH program that have no payor source.

/2013/ These programs may be affected in the move to Medicaid Managed Care, but those issues are still being worked out. //2013//

Collaboration - Department for Behavioral Health, Developmental and Intellectual Disabilities and Addiction Services (BHDIDAS) is a collaborative partner on a number of maternal and child health programs:

- The KIDS NOW Substance Abuse in Pregnancy program targets women at risk or abusing alcohol, tobacco, and other drugs during pregnancy. LHDs screen pregnant women for alcohol, tobacco, and other drugs and women who fall into lower level risk groups can be referred for prevention services, while those in the high risk category can be referred for a fuller substance abuse assessment and case management to the Regional Mental Health centers. As a result of this collaboration, thousands of pregnant women struggling with substance abuse issues in KY are being reached.

- The Early Childhood Mental Health (ECMH) Program, funded by KIDS NOW and co-administered by MCH and DBH, provides direct services to children identified through childcare as having behavioral or possible mental health issues. Through this program there is a full time early childhood mental health consultant located in each regional mental health center to provide or refer these services. They also provide consultation to the childcare center and train childcare staff to problem solve classroom behavior problems and build resiliency in children. Another component of this program is to build capacity of mental health professionals working with children birth to five years of age by providing free trainings. This program has been presented as a "Model that Works" at the AMCHP national meeting in 2006. The Specialists work collaborative with the HANDS program and the Child Care Health Consultation program to identify families in need of services; they are also trained to deal with Perinatal Depression.

- MCH staff serves on the Suicide Prevention Advisory Group. DBHDID staff also serves as a member of the State Child Fatality Review Team.

- Substance Exposed Infants: The Substance Abuse Prevention team in DBH, as part of the KIDS NOW Early Childhood Development Initiative, has been working with many of the MCH programs including the Prenatal program, Family Planning, Well Child and the KY Birth Surveillance Registry. This collaboration is a statewide effort aimed at increasing the health of all babies by decreasing the use of alcohol, tobacco and other drugs during pregnancy. The program components will include outreach efforts aimed at better identifying pregnant and postpartum women in need of prevention or treatment, and collaborative efforts between substance abuse prevention and treatment services to provide a continuum of care.

- Collaborations at the Commissioner's level include the State Interagency Coordinating Council (SIAC) for Children with Emotional Disabilities. This is the oversight body for the KY SEED project, continue with the KY SEED Grant -- Systems to Enhance Early Development. This is a $9 Million SAMSHA grant to develop and implement integrated systems of care for familes of children birth to five who have social, emotional, and behavioral needs. Several MCH program staff, including the HANDS program, are participating in this collaborative effort. The KY Partnership for Families and Children is the family voice for this initiative.

Collaboration - Kentucky Department of Education (KDE)
The KIDS NOW Initiative is housed in the KDE, Division of Early Childhood, but works across department lines with PH, Education, CCSHCN, Child Care, and DBH. The goal of the initiative and all partners is that "all children in KY are healthy and safe, possess the foundation that will enable school and personal success, and live in strong families that are supported and strengthened within their communities." There is a strong evaluation component of the entire initiative and programs regularly report their progress to the Early Childhood Development Authority board, which makes funding recommendations and provides accountability.

/2013/ These roles have been transitioned to the Early Childhood Advisory Council, which included DPH representation. //2013//

KY receives a CSH grant from the CDC - Division of Adolescent School Health (CDC-DASH). This allows a continuation of the infrastructure building and program development to promote the health of our youth so that our children become healthy, productive citizens. KDE and DPH partner together to administer and evaluate a CSH program at the state level. Through this state infrastructure, schools and school districts, with assistance from LHDs and other partners, strengthen local CSH Programs.

CSH consists of an eight-component national model include health education, physical education, health services, nutrition services, counseling/psychological services/social services, health school environment, health promotion for staff and family/community involvement. This model is an organized set of policies, procedures, and activities designed to promote and sustain the health of students and staff. Many other programs within the Division are linked with this project, specifically through a CSH Interagency committee, which includes representatives from Tobacco, Substance Abuse Prevention, Asthma, HIV/AIDS, Well-Child, Abstinence Education, Family Planning, Diabetes, Nutrition, Obesity, Cardiovascular Health and Physical Activity. The Foundation for a Healthy Kentucky (http://www.healthyky.org/), has supported coordinated school-based projects through funding of school grants to expand, replicate or enhance CSH Programs in KY communities. This group has developed a school-based resource guide book on physical activity, nutrition, tobacco and asthma (PANTA). The handbook was developed by the DPH and the KDE to provide assistance to schools in designing and planning policies and programs, encouraging environmental change, and promoting overall health of students, staff and the school community. This resource helps schools make the changes required by SB 172, our school nutrition bill. Resources are provided that encourage needs assessment [CDC's School Health Index], evidenced-based curriculum, best practices, model policies and answers to frequently asked questions. This guide is arranged in such a manner that it can be used as a whole document or by subject -- physical activity, nutrition, tobacco and asthma (PANTA). This guide is currently in the process of being updated, and adding sections on drug and alcohol use, injury and violence (including suicide), sexual risk behaviors, and dental health.

School health nursing is another area of collaboration. By law, DPH funds half of a position for a school health nurse consultant at the KDE, and Education funds the other half. This nurse consultant works in partnership with the MCH School nurse consultatant, providing leadership, technical assistance, protocols, training, and alignment with the KBN for nurses in the school setting. About half of the school health nurses in KY are now health department nurses; others are employees of the local school districts.

Collaboration - University of Kentucky

UK houses the KY Injury Prevention Research Center, which works with the DPH Child Fatality Review and Injury Prevention program to facilitate, develop policy, gather and analyze data to identify trends, patterns and risks, provide technical assistance and training, and to review, make proposals and implement strategies to improve the child fatality review and injury prevention system, with an emphasis on coordinating partnership prevention efforts. The Injury Prevention center also works with the DPH Epidemology Division on statewide injury surveillance and cooperates with CDC on the Violent Death Reporting System.

/2012/ Additional collaboration with UK includes MCH Workforce and Policy Development with the UK MCH Certificate Program in the College of Public Health. DPH's Prenatal program contracted with UK for LHD prenatal nurse training in 2011. DPH also expanded a contractual agreement in 2011 with UK for additional Well Child training in support of the existing training through U of L. DPH provides internships for UK students and personnel from DPH guest lecture on a regular basis for courses in the College of Public Health. DPH continues to contract with UK's Infant Intensive Care Unit in order to receive data related to neonates and transfers to and from the facility. This contract coordinates referral systems with the KY Birth Surveillance Registry, First Steps, HANDS, and Newborn Screening and provides consultation, education, and

training for healthcare providers in the stabilization of acutely ill children. //2012//

The DPH also has an active collaboration with the state-wide network of county extension agents through the UK Cooperative Extension Agency. Community topics include nutrition, physical activity, smoking cessation and general health promotion.

/2013/ Collaboration - Multiple Partners

DPH received an American Recovery and Reinvestment Act (ARRA) Stimulus Grant for years 2010-2012 to increase fruit and vegetable consumption through a farm to school program and increase physical activity in early child care. These two projects strengthened partnerships with school and child care stakeholders and developed a foundation to improve nutrition and physical activity in each setting.

Early Child Care Nutrition and Physical Activity
An Early Child Care and Education Committee formed to identify needs for improving nutrition and physical activity. Stakeholders included representatives from the Division of Child Care, Division of Child Care Licensing, KDE Nutrition Services Child and Adult Food Program, Preschool, STARS, Early Child Care Councils, UK Human Development Institute and Louisville YMCA. The group decided to identify nutrition and physical activity resources and recommendations; provide trainings and pilot projects based on best practices and develop a consistent message on evidence based behaviors targeting caregivers of two to five year olds. Nutrition and Physical Activity Self-Assessment in Child Care (NAPSACC) program is as researched-tested intervention designed to enhance policies, practices, and environments in child care by improving the nutritional quality of food served, amount and quality of physical activity, staff-child interactions, facility nutrition and physical activity policies and practices and related environmental characteristics. The combination of system and environmental changes and staff training creates healthy environments for children attending child care centers

Northern KY, Barren River and Green River HDs implemented the NAPSACC program in 28 childcare centers within their districts. In total, the NAPSACC program impacted 461 childcare center staff and 2418 children enrolled in all centers combined. Seven NAPSACC center staff trainings were held within the three health districts. 205 total childcare staff attended the trainings, with the purpose of the training being to educate all center staff on childhood obesity, childhood nutrition and physical activity, the role the childcare center can play in impacting the health of the children, and the importance of their own personal health and wellness. Among the results of the program were healthy menu changes, increase in amount of active play time and the development of physical activity and nutrition policies.

5210: Healthy Families Know These Numbers Campaign
Early Child Care stakeholders said that centers can make changes in nutrition and physical activity policy but in order to be effective parents needed to understand why the changes are being made. Stakeholders were calling for a consistent message for healthy eating, screen time limits, physical activity and beverage limits. The 5-2-1-0 Healthy Numbers for KY Families recommends: Five: Eat five or more servings of fruits and vegetables each day; Two: Limit screen time to no more than two hours a day; One: Be physically active at least one hour a day; Zero: Don't drink sweetened beverages. The campaign is designed to give parents, healthcare professionals and day care operators a memorable way to talk about the key evidence-based behaviors that reduce childhood obesity. Webinars and trainings were provided to health professionals and communities to learn about the evidence behind the campaign and implementation strategies.

A series of other trainings have provided for child care health consultants, childcare trainers and childcare providers on the best tools for nutrition, physical activity and

screen time reduction for day care centers In addition the UK Department of Kinesiology developed a manual and provided training on childcare setting and physical activity.

Farm to School
A KY Farm to School Taskforce was established to bring together stakeholders from the school food system to look at the opportunities and barriers to promoting local foods in schools. Taskforce members represent DPH, KY Department of Agriculture, the KDE, Community Farm Alliance, UK Cooperative Extension, UK College of Public Health, Action for Healthy Kids, Foundation for Healthy KY, a local chef and local school food service directors. Together this group works on initiatives to help students eat more fruits and vegetables, provide more markets for farmers and to increase the participation of the school lunch program through the promotion of local foods. This group provided mini grants trainings and TA to 13 communities that received $5000 mini grants, developed a KY Farm to School Resource Guide and KY Farm to School Curriculum. //2013//

Collaboration-Governor's Office of Electronic Health Information (GOEHI)

The GOEHI received a federal grant to improve health services for individuals with mental health or substance abuse conditions, used to develop infrastructure to support the electronic exchange of health information among health care providers and CMHCs. This will improve record-keeping and tracking of patient history as well as improved overall health of patients.

Collaboration - Commission for Children with Special Health Care Needs

CCSHCN has a Memorandum of Agreement (MOA) with the Department for Medicaid Services that enables the agency to provide services for applicable Medicaid eligible children enrolled for Title V/CYSHCN services. This agreement assures that services are provided in accordance with the Title XIX State Plan and EPSDT special services as required by OBRA 89.

CCSHCN also operates under a Memorandum of Understanding (MOU) with the Department for Community Based Services (DCBS) and is providing nursing consultative services in 8 of the 9 DCBS regions for children in the foster care system. This program was initiated in February 2005 to provide services for children who are medically fragile. It was expanded statewide in July 2006 to include the entire foster care population. The Nurse Consultants provide consultation to the DCBS social workers and foster care families on medical issues, interpret medical records and reports, assure updated portable health summaries and enhance care coordination of all services. In 2007, it was further expanded in a collaborative effort with the University of Kentucky to open (via a separate MOA) the Medical Home Clinic in the Lexington office, which provides primary care services to children in foster care in the central region of the state.

The Early Hearing Detection and Intervention (EHDI) program maintains many relationships in the administration of Kentucky's legislatively mandated newborn hearing screening program. In addition to the partnerships with the state's birthing hospitals, the program collaborates with the Commission on the Deaf and Hard of Hearing and the Kentucky chapter of Hands and Voices. Since 2006, a partnership with Vital Statistics has allowed the program to receive newborn hearing screening results for every child born in Kentucky electronically through the KY-CHILD database. Ongoing efforts at this time include work to expand online data transmission to allow community audiologists and early interventionists to electronically transmit diagnostic assessment results to the EHDI program. New efforts are focused on working with Part C leaders to further expand Early Intervention services that more effectively meet the specific needs of newborns diagnosed with permanent hearing loss. In March 2009, Governor Beshear signed HB 5 which requires audiology diagnostic sites who wish to be included as approved centers for pediatric audiological testing to agree to meet specific requirements, including best practice standards and reporting to the EHDI program.

An agency partnership with Home of the Innocents (a private child caring agency providing

hospital-like and "home-away-from-home" environments for medically fragile children) allows Louisville therapeutic staff (PT, OT, SLP) to reside and provide services at the Home of the Innocents facility. This arrangement allows CCSHCN patients and staff to utilize the advantages of a new facility, with state-of-the-art equipment, that is closer to the downtown area & medical complexes.

Memoranda of Agreements are maintained with the University of Kentucky and the University of Louisville to provide Hemophilia Treatment Centers covering the entire state's bleeding disorder population

CCSHCN also provides assessments for the state's Disability Determinations Services division on behalf of the Social Security Administration for residents of Kentucky.

Currently, CCSHCN is working towards Memoranda of Agreement with First Steps to provide audiological services and to improve and streamline interpretation services.

CCSHCN collaborates with the Kentucky Council on Developmental Disabilities (KCDD). The mission of the Kentucky Council on Developmental Disabilities is to create change through visionary leadership and advocacy so that people have choices and control over their own lives.

CCSHCN maintains numerous additional relationships with other state agencies. Programs with which our agency collaborates include: local schools, Office of Vocational Rehabilitation, Special Needs Adoption Program, the Kentucky Community & Technical College System, local health departments, Family Resource Youth Service Centers, Regional Interagency Transition Teams (RITT), State Early Childhood Transition Committee, KIDS NOW, State Interagency Council on Services to Youths with Severe Emotional Disabilities, and the state Child Fatality Review Program. Agency association with these entities allows us to further develop goals for the agency, provide community training, streamline services for children with special health care needs in their community and schools, educate, as well as prepare children for the transition into adulthood.

/2012/ CCSHCN now provides nursing consultation statewide.

CCSHCN has initiated a program that allows families of children with permanent hearing loss to be partnered with parents in the Hands and Voices group to help these families navigate the system of care for deaf/hard of hearing infants and children. The mentor parents assist families in an unbiased way to make decisions that are appropriate for their family with regard to communication mode, intervention services, and providers.

CCSHCN has signed Memoranda of Agreement with First Steps to provide audiological services and is administering their interpreter services.

CCSHCN looks forward to the possibility of coordinating with DPH's MCH epidemiologist, who (pending grant funding) will work onsite directly with CCSCHCN staff on a biweekly basis to assist in program evaluation, analysis of MCH data, data linkage projects as well as joint special projects.

CCSHCN has been collaborating with the Kentucky Department of Education to follow up on school scoliosis screening programs and hearing conservation programs. Working toward building a stronger relationship in the near future. Under Kentucky law, schools have the responsibility to screen, while CCSHCN is to provide guidance through consultations and resources for the implementation of the screening programs and subsequently as a direct service provider to children who fail these screenings at school.

CCSHCN was awarded a State Implementation Grant and will begin working with Kosair Children's Hospital's Bridges to the Future transition program and would also like to extend

collaborative programs to the eastern part of the state by partnering with UK. To fulfill an additional objective for this grant, CCSHCN also hopes to develop partnerships with community free health clinics for uninsured patients and to provide family/professional support for Hispanic and other families without insurance coverage. //2012//

/2013/ CCSHCN's information system now contains a designation indicating whether a child is receiving KYs Part C Early Intervention Services, or "First Steps".

The State Implementation Grant/D70 partnership has convened a steering committee comprised of internal and external stakeholders and representatives from professional groups and families to direct the activities of the grant. CCSHCN is collaborating with Kosair Children's Hospital's Bridges to the Future transition program to expand transition services to children outside the CCSHCN program. This program provides a portable health record and transition resources to enrollees and their families, and will be instrumental in developing a register of physicians committed to serving transition-age CYSHCN as they become adults. Proposed grant activities include transition day workshops, school transition fairs, a parent collaborative, physician referral resource, and patient/physician portals to the electronic health record. At this time, CCSHCN has put on hold plans to provide family/professional support for Hispanic families without insurance coverage, pending the employment of part-time parent consultants.

As administration of the DMS program switches over to the new managed care organizations (MCOs), new contracts have been negotiated and adjustments to processes will have to be made to ensure that funding remains stable. CCSHCN is collaborating with MCOs to provide care coordination for CYSHCN who are enrolled in the CCSHCN program, to expand provider networks, and to improve identification of CYSHCN and referrals.

CCSHCN is working with community partners to investigate gaps or duplication of services and is addressing its role in new areas, such as sickle cell, autism, and behavioral health.

To promote public-private partnership and in an effort to use newly-developed community resources in an efficient way, CCSHCN is looking for opportunities to collaborate with the Home of the Innocents, given their recently expanded capacity to serve, especially in the areas of dental and pharmacy. Home of the Innocents is a prominent leader in providing specialized care to CYSHCN from across the state and to children involved in the child welfare system. //2013//

F. Health Systems Capacity Indicators

The Department for Public Health (DPH), Division of Maternal and Child Health (MCH), has made significant improvements in its capacity for data analysis and utilization. The SSDI grant has enabled MCH to bring in high quality trainings for epidemiology staff that would have otherwise been impossible, as well as technical assistance from business school professors, biostatisticians, and other experts in advanced analysis. In addition, we have been able to achieve linkages of databases that provide a richness and depth of information previously unavailable for program implementation and evaluation. Plans for further linkages and analysis continue to grow, and these will allow for more specific, data driven strategies and programs that will be required in tight economic times.
The state MCH programs work closely with Medicaid and other agencies to develop strategies to enhance Health Systems Capacity as measured on these indicators. Kentucky Medicaid has been very supportive of providing care for MCH populations and assisting DPH with data from Medicaid services files. The Medical Director for Medicaid, Dr. Tom Badgett, is a pediatrician.

Health Systems Capacity Indicator 01: The rate of children hospitalized for asthma (ICD-9 Codes: 493.0-493.9) per 10,000 children less than five years of age.

In March, 2009, the Kentucky Respiratory Disease Program (KRDP) completed the Kentucky Asthma Surveillance Report, 2009 and the 2009 Kentucky State Plan for Addressing Asthma. The Kentucky Asthma Surveillance Report provides data reflecting the burden of asthma in KY. Data from this report provided important information used to direct the efforts of the Kentucky Asthma Partnership during the strategic planning process to create the state plan.
Both documents are being disseminated to key partners and have been made available on the programs web-site. Additionally Asthma Area Development District Profiles were developed and are revised each year giving specific regions the data they need to prioritize their goals. These are also posted on the website and disseminated widely to partners.
Beginning in 2007 DPH provided funding to start a KRDP through Preventive Health and Health Services Block Grant funding. Then in September 2009, the KRDP received the CDC "Addressing Asthma from a Public Health Perspective" grant. KY is currently in the third year of funding with the anticipation of a fourth year of funding. The cooperative agreement requires the KRDP to focus on specific populations within KY and to implement specific interventions to support the goals and objectives of the KY State Plan for Addressing Asthma.

There are many specific successful interventions of the KRDP. The KY Asthma Partnership is now in the ninth year with over 90 organizations and partners participating through a list-serve, newsletters and a quarterly meeting which features training and updates, work on the strategic plan, reports from partners and coordinated projects. This effort is led by the KRDP and focuses on increasing capacity and collaboration.

KRDP collaborates with the American Lung Association of the Midland States to provide their Asthma Educator Institute twice annually. Scholarships for nurses and health educators working with populations with Asthma in FQHCs, health departments, and schools will be provided in order to improve their competency in asthma management and treatment. This curriculum can also lead to certification as an Asthma Educator after an exam is passed and the amount of certified Asthma Educators in KY has increased over 300% in the past three years.

KRDP partners with the KDE, the Kentucky School Boards Association, and the Kentucky Association of School Administrators to develop a statewide asthma management plan for KY schools. The plan would include collecting data and providing information to key partners and stakeholders; educating school administrators, faculty, staff, and students on appropriate asthma management and emergency response; and communicating among schools, students with asthma, their parents and their physicians.

KRDP developed a resource manual for schools entitled "Creating Asthma Friendly Schools Resource Guide". The resource guide covers seven steps to creating a more asthma friendly environment for school age children.

The Asthma 1-2-3 Curriculum is promoted to individuals working in schools and daycares. This facilitator training is now available face to face and by webinar from the American Lung Association of the Midland states, leading to an increase in knowledge and understanding of Asthma triggers and management while the child is away from home. An evaluation process for this training was completed by the Evaluator for the Asthma Grant.

Health Systems Capacity Indicator 04: The percent of women (15 through 44) with a live birth during the reporting year whose observed-to-expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.

Following KY's switch to the new birth certificate in 2004, this indicator was calculated differently than in the past and therefore the numbers are not comparable. Like other states who switched, we struggled with how to best calculate this indicator based on the new data source.

We currently use the method established by the National Center for Health Statistics for

calculating entry into prenatal care. Due to this new method change, we have seen a decline in the percent of women with adequate and adequate plus prenatal care. Detailed multi-variate logistic regression analysis has been conducted to assess if the decline is real. Results from the analysis comparing births prior to and after the new birth certificate indicate the decline is due to the new method of calculation and not a reflection of decline in the receipt of services, since significant demographic variables remained the same for both groups of women that received adequate and adequate plus prenatal care. Preliminary data is now indicating a rise in the number of women receiving adequate and adequate plus prenatal care.

Currently KY offers these prenatal programs to serve this population: Prenatal Programs in LHDs with Folic Acid Supplementation and assured referral to appropriate providers in communities; LHD nurses are specifically trained to provide education and counseling related to prenatal care and to communicate the importance of early and ongoing prenatal care. Healthy Babies are Worth the Wait (HBWW) has expanded to 8 locations across the state. The March of Dimes in conjunction with MCH updated the HBWW Toolkit in 2010 for use by providers and communities. Centering Programs are offered by UK in multiple sites and at Trover Clinic in Madisonville to address prenatal and oral health for pregnant women. The Young Parents Program of UK has expanded to multiple clinic sites across the state, providing comprehensive medical and psychosocial services to adolescents who begin prenatal care prior to their 19th birthday. Beginning in FY13, LHDs will assign an MCH Coordinator to guide and assure that pregnant women and children receive appropriate prenatal and well child services. Referrals for specialty and community services will be made when indicated upon positive health risk assessments.

Health Systems Capacity Indicator 02: The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.

The Department for Medicaid Services (DMS) administers statewide EPSDT Outreach through a contract established with DPH. EPSDT outreach further expanded verbal notification activities to enroll more uninsured and underinsured children in the Medicaid program and KCHIP programs. DPH enhances EPSDT Outreach providing
technical assistance and helping health departments set specific goals and objectives including KCHIP Outreach activities, monitoring statewide and county outreach activity and expenditures goals and objectives quarterly and as needed, providing LHDs with training and technical assistance as well as feedback about program performance, and collaborating with DMS and LHDs in 120 counties to increase public and provider awareness of KCHIP and increase enrollment. DPH enhanced statewide LHD outreach EPSDT verbal notification activities to enroll more uninsured and underinsured children in the Medicaid program and KCHIP programs. Additionally, the DPH EPSDT Outreach program participated in statewide
videoconferences provided to health departments to promote outreach budget and planning, EPSDT Outreach goals and objectives, and provide education about appropriate outreach coding and reporting.

Through CY 12, LHDs in 120 counties helped enroll more children in Medicaid and KCHIP while working with community agencies to improve partnerships with schools and providers, conducting EPSDT outreach verbal notification activities to inform families of the need for children's preventive health exams, and providing families with materials and assistance to complete KCHIP applications. DPH reinforced EPSDT Outreach goals and activities for state fiscal years 11 and 10, by providing EPSDT Outreach training presentations through two (2) statewide videoconferences attended by health department administrators and EPSDT clinical and support staff members.

KCHIP application Training is now provided on the Kentucky Department of Medical Services website for community providers, schools and agencies. KCHIP claims for this indicator remain lower than previous years and this has been investigated by DPH and DMS. Findings show children are actually qualifying for Medicaid and are receiving services through Medicaid giving the

impression that KCHIP enrollment is down when in fact it is not.

Health Systems Capacity Indicator 03: The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.

After a period without active grass roots KCHIP Outreach from CYs 2004-2008, effective November 1, 2008, Governor Beshear initiated a statewide plan to increase the number of children enrolled in KCHIP by more than 35,000 children. The following DMS administrative changes were implemented and decreased barriers that have kept families from enrolling their children in the Kentucky Children's Health Insurance Program (KCHIP): eliminating the face to face interview, simplifying the KCHIP application, distributing KCHIP Mail In applications, extending the grace period for replying to requests for more information to complete applications, training statewide community providers and agencies to assist families with enrollment processes, hiring more personnel to process applications and increase outreach. In state fiscal year 09, DMS hired a full-time Outreach Coordinator and partnered with DPH, LHDs, statewide community providers and agencies to increase awareness of KCHIP and conduct outreach to the children estimated to be uninsured in KY and to enroll additional children in KCHIP by June 30, 2010. DPH and the DMS contracted to conduct KCHIP Outreach through activities through statewide LHD Health Access Nurturing Development Services (HANDS) as well as EPSDT Outreach programs.

DPH enhanced EPSDT Outreach in state fiscal year 2009 by increasing guidance on specific goals and objectives including KCHIP Outreach activities, monitoring statewide and county outreach activity and expenditures goals and objectives quarterly and as needed, providing LHDs with training and technical assistance as well feedback about program performance, and collaborating with DMS and health departments in 120 counties to increase public and provider awareness of KCHIP and increase enrollment. To increase provider awareness of KCHIP and facilitate enrollment, DPH and DMS partnered to present statewide videoconferences to LHDs and statewide community providers, schools and agencies. The videoconference was made available to partners on line through TRAIN. Additionally, DPH maintained and monitored contracts with two health departments to administer the statewide KCHIP outreach hotline, providing information about KCHIP enrollment and enhanced statewide LHD outreach EPSDT verbal notification activities to enroll more uninsured and underinsured children in the Medicaid program and KCHIP programs.

Investigation into decreasing numbers by DMS has revealed more children being born are deemed medically eligible status instead of with a KCHIP eligible status. The KCHIP Outreach hotline has been moved to DMS with Medicaid Membership Services, DPH is no longer monitoring or providing KCHIP Outreach services through the hotline. KCHIP application Training is now provided on the Kentucky Department of Medical Services website for community providers, schools and agencies.

Health Systems Capacity Indicator 07A: Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.

The percent of potentially Medicaid eligible children who received a service paid for by Medicaid continues to be in the 95% range. These services are provided by LHD nurses in the clinic and school settings. LHDs collaborate with local school boards for provisions of child and adolescent preventive health services for school age children. Health departments around the state now have over 500 certified nurses, providing school health services locally.

The Well Child Certification training process has continued, with another 143 nurses trained in 2011. The web-based curriculum on Bright Futures and EPSDT for health care providers is presented as 23 web casts. The web base provides a pre and post-test with printable handouts attached with each web cast. After successful completion of the 23 web casts and passing the

post-test, the health department nurse participates in a 3 day practicum where he/she completes 25 comprehensive physical exams precepted by an MD, certified APRN, pediatric nurse practitioner or another well child nurse that has been certified for over 1 year. The physical exams are performed on the following age groups: infant, toddler, preschool age, school age, and adolescent children. Upon completion of these two requirements, the nurse then receives a certification to provide well child/EPSDT services. Updates are required every 3 years and provided annually on TRAIN by the DPH.

Health Systems Capacity Indicator 09A: The ability of States to assure Maternal and Child Health (MCH) proram access to policy and program relevant information.

Kentucky is currently in the first year of a two year State Systems Development Initiative (SSDI) grant period. In FY12, linkage efforts will focus on 2009 First Steps participants to their live birth certificate and Women's Infants and Children (WIC) program data to the live birth certificate. A pilot Pregnancy Risk Assessment Monitoring System (PRAMS) project will be undertaken in 2013 for eight months. Biostatistics trainings will be provided to all MCH epidemiologists by Dr. Arne Bathke from the University of Kentucky.

See Section B. Agency Capacity, Capacity: MCH Data Analysis and Surveillance, State Systems Development Initiative (SSDI) for further details.

IV. Priorities, Performance and Program Activities

A. Background and Overview

The Kentucky Department for Public Health (DPH) is the organizational unit of KY state government responsible for the development and administration of public health progorams and activities for the 4 million citizens of KY. Activities and programs fall within the traditional roles of public health - prevention, protection, and policy.

DPH uses local health departments (LHDs) in all 120 counties as the main provider of direct services for public health programs. There are 58 administrative LHD units, some district health departments and some single county, but each of KY's 120 counties have a LHD. These LHDs are not arms of the state health department, but are agencies of local county government, run by a local Board of Health and the County Judge-Executive. DPH is charged with providing a single personnel system for the LHDs, and serves as the vehicle for distributing state general funds and federal grant funds to the LHDs. State health department staff provide program administration, such as training and protocol development to support the services that are delivered locally. This guidance is published in the Administrative Reference(AR) and Public Health Practice Reference (PHPR- clinical protocols). State public health staff are more directly involved in population based services such as newborn screening, and in infrastructure activities such as surveillance, needs assessment, evaluation, planning, standards development, and quality assurance. New progress in information technology is opening the door for new ways of assessing and delivering public health. KY has already implemented a web-based system for electronic submission of both birth certificate data and newborn screening data in a single system at hospitals. An electronic dealth registry and immunization registry are being piloted this summer. KY has also recevied a grant to implement a pilot Health Information Exchange in Lexington, which should also begin in 2010. Access to more timely and comprehensive data will allow for better data-driven decision making and public health improvements.

Of the activities for protection, DPH has had the most growth and improvement in emergency preparedness. Katrina in 2005 was the first big challenge for the systems that had been developed after 9/11. KY responded well, sent several teams (enviromental teams covered there for months) and also received refugees from the disaster. All of this tested our systems and resulted in improvements. One was developing a network for health care workers to volunteer for such disasters, that Public Health can now access whenever surge capacity is needed. In winter 2008 KY experienced the worst winter-time natural disaster in our history with a severe ice storm in western and central Kentucky. followed by flooding in western, then eastern KY. CDC and other federal partners have been complementary of KY's responses.

Policy is the foundation of improving public health, and DPH directs much effort towards not only developing model policies to address the major health problems of the state, but in gathering support for them through community coalitions, partners, and advocacy groups across the state. In most cases, local policy change is the first step in moving the state towards state-wide policy changes. However, in the current economic downturn, DPH and all parts of state and local government, are intensely examining what funding is available and how best to spend it. This in itself in a major policy decision. DPH is holding meetings with stakeholders, especially LHDs to determine what is core public health and prioritize which services are most essential to Kentuckians.

Thus, the 2010 MCH state-wide needs assessment is a timely review of what KY's citizens think are the most important health problems in the state. As described in the Needs Assessment Document, DPH utilized web-based provider survey, Community Forums, and Statewide Patient Survey as a means of obtaining input from our providers, patients, and communities. These efforts which began in 2008 and were conducted in 2009 have been instrumental in determining the state priorities and new State Performance Measures. Both the Commission for Children with Special Health Care Needs and DPH welcome questions from readers. Contact information for

the main offices of both agencies are listed below. Upon receipt of your call, you will be connected to the appropriate staff.

Kentucky Department for Public Health, Division Maternal and Child Health 502-564-4830

Kentucky Commission for Children with Special Health Care Needs 502-429-4430

B. State Priorities

TITLE V 2010 PRIORITIES AND MEASURES FROM THE NEEDS ASSESSMENT

Priority 1. Reduce rates of substance abuse and smoking in pregnant women and teens.
The Title V program will not be able to take on this entire issue, but will continue to work closely with those agencies that do have this responsibility and bring focus on maternal and child health populations. DPH hosted state-wide community forums on tobacco in 2005 and now has 27 communities with tobacco-free ordinances. The cigarette tax in KY has been increased twice in the last 5 years in KY, but is still below the national average. The tobacco program has held youth advocacy programs around the state that have been very effective. This year's emphasis from the Tobacco Control program will be 24/7 tobacco-free school campuses. The Substance Abuse Division of Behavioral Health has a number of initiatives on which we will work collaboratively. To measure progress on these issues, Kentucky will rely upon:

a. NEW State Performance Measure #02: The percent of Kentucky High School students who smoked cigarettes on one or more days of the past 30 days. Source: YRBS and Youth Tobacco Survey. Since 90% of adult smokers take up smoking before the age of 18, this measure will allow us to target initiation of this risk behavior, which is often the precursor of other substance abuse behaviors.

b. NEW State Performance Measure #05: The percent of Kentucky residents age 12 through 17 who report illicit drug use in the last year. Source: YRBS Initiatives in the schools and policy level changes hold promise for reducing this number.

c. NPM # 15 -- Smoking in the third trimester of pregnancy. Source: Birth certificate data
Kentucky ranks next to worse on smoking in pregnancy, and has rates nearly twice the national average; one in four pregnant women in Kentucky continue smoking during pregnancy. Several initiatives are underway to address this issue, but to make a significant impact will require more than individual level interventions.

Priority 2. Reduce rates of obesity in maternal and child health populations in Kentucky, including children and youth with special health care needs.
KY has actively worked on obesity prevention since 2004 when DPH conducted state-wide forums in 11 sites. From these came a state plan, a state-wide coalition, the Partnership for a Fit KY, and local community coalitions at the 11 sites. KY in 2006 passed one of the strongest school nutrition bills in the country. Mandatory physical activity for schools has been proposed but not yet enacted. Recent efforts are focusing on policy change, including farms to schools, built environment, and child care policies. Pediatric obesity is a priority for CHFS Secretary Miller and Commissioner Hacker. DPH collaboratively funds local health departments through the preventative services block grant, MCH block grant (medical nutrition therapy), and Healthy Communities grants for local initiatives to combat obesity. KY AAP received a grant from Robert Wood Johnson to hold Advocacy trainings on Pediatric Obesity, and has also developed an office toolkit to address the issue. Contextual factors in Kentucky, including high rates of poverty and geographic isolation in rural areas make the challenge particularly big for Kentucky. Obesity is a particularly important issue for CYSHCN, hence the need for a specific State Performance Measure for this population. However for both agencies and among all the groups participating in the 2010 Needs Assessment process, there is a high degree of concern which should translate to a bias toward action. Grassroots activities are increasing. Policy level approaches are also

under development.

Measures for tracking progress will include:

a. NEW State Performance Measure #01: The percentage of first time births to Kentucky resident women age 18 and older who had pre-pregnancy BMI's in the overweight or obese categories. Source: Kentucky Birth Certificate Files. This measure is a reflection of preconception care, as well as increased risk for the pregnancy, as obesity is more and more associated with adverse birth and delivery outcomes.

b. NEW State Performance Measure #07: Increased percent of children served by Kentucky CCSHCN with BMI at healthy weight (between 5th and 85th percentile). Source: CCSHCN CUP (Patient Health Information System).

c. NPM #11 -- The percent of mothers who breastfeed their infants at 6 months of age. Breastfeeding is a first line of protection against developing obesity later in life.

d. NPM #14: The percentage of 2 -- 5 year olds with greater than 85th percentile BMI. In many cases, children are already obese before they get to school age. This measure allows us to target and track low-income children in early childhood where there are more opportunities for true prevention and addressing lifestyles.

d. Children and youth overweight and obesity will still be monitored from existing sources, but not used as a measure of progress for the block grant. Numerous initiatives targeting school age children and school policies are underway in Kentucky to address this population.

Priority 3. Reduce the rates of births to teen mothers in Kentucky. One of the top three topics in nearly every part of the Needs Assessment, teen pregnancy is a serious concern for communities all across the Commonwealth. It is also a symptom of the issues underlying not only teen pregnancy, but also substance abuse, smoking, suicide, and other mental and physical health issues in the teen population. Efforts around this need will be lead by the Adolescent Health coordinator in the Division of Women's Health, who currently works closely with the Title V MCH program. A stakeholder group has been meeting for several months (since the forums), focus groups with teens have been completed, and a multidisciplinary stakeholder group is developing a state plan for action.
Since teen pregnancy is addressed in a current NMP, Kentucky will monitor progress using that measure:

a. NMP # 8: The rate of births (per 1000) for teens ages 15 through 17. Data Source: Kentucky Birth Certificate Files

Priority 4. Reduce the number of Kentucky children dying from child abuse or maltreatment. Deaths from child abuse and maltreatment are exceedingly tragic, and children are especially vulnerable at age less than 5. Kentucky currently leads the nation in child abuse deaths, increasing the urgency of this need.
In collaboration with the Division of Protection and Permanency, MCH is engaging in more discussion of how to address this need on a number of fronts. The first barrier is collecting accurate and complete data, as there is no common definition of child abuse and it rarely is listed as a cause of death on death certificates. In addition, most programs to "prevent" child abuse are secondary prevention, targeted at recognizing the signs after the child abuse has occurred. Kentucky is also now exploring evidence-based primary prevention programs such as Triple P.

a. NEW State Performance Measure #04: The proportion of Kentucky children birth to 5 years of age who die from child abuse. Data Source: Protection and Permanency Child Fatality Review data files.
b. National Health Outcome Measure (NOM) # 06: The child death rate per 100,000 children

aged 1 through 14.

Priority 5. Decrease the Infant Mortality Rate and eliminate the disparities in Infant Mortality in Kentucky. Preterm birth is one of the three leading causes of infant mortality, and the only cause that has been increasing in the last decade. Since the Surgeon General's Conference on the Prevention of Preterm Birth in 2008, it has been recognized that contextual factors and social determinants of health play as important a role in preterm birth as medical risk factors.

Kentucky has a project studying the contextual factors relating to preterm birth in Louisville, KY, in neighborhoods with high populations of African-Americans live. In addition, the Appalachian area is a disparate population with high concentrations of poverty and similar contextual factors. The other focus of prematurity prevention for Kentucky is the Late Preterm Births, those occurring between 34 0/7 weeks and 36 6/7 weeks gestation. Kentucky's Healthy Babies are Worth the Wait initiative, with March of Dimes and Johnson and Johnson, has been recognized nationally for emphasizing strategies to address late preterm births as a population at risk and potentially preventable preterm birth.
Progress on these efforts will be measured by:

a. NEW State Performance Measure #03: Percent of singleton live births to Kentucky residents that are 34-36 weeks (late preterm) at delivery. Data Source: Kentucky Birth Certificate Files

b. NPM #17: Percent of Very Low Birth Weight Infants delivered at facilities for high risk deliveries and neonates

c. National Health Outcome Measures #01 through #05 -- infant mortality, black/white infant mortality ratio, neonatal mortality, post-neonatal mortality, and perinatal mortality rates.

d. Health Systems Capacity Indicators # 05 A, B, C, and D, covering low birth weight, early and adequate prenatal care, and infant mortality by Medicaid vs. non-Medicaid

Priority 6. Improve the Oral Health Status of Kentucky's children, youth, and pregnant mothers. Improving oral health in Kentucky is one of the major access to care issues in the state, as there are few dentists in rural areas, fewer pediatric dentists, and many dentists even in urban areas who do not accept Medicaid patients due to low reimbursement. In addition, there are cultural barriers, as many families accept poor oral health as the norm.

Kentucky will measure progress on this need by:

a. NPM # 9: Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

b. Health System Capacity Indicator #07A: Percent of Medicaid eligible children ages 6-9 who received a dental service

c. State Performance Measure #06 (continuation): Percent of Medicaid-covered women who received at least one dental visit during their pregnancy.

Priority 7. Improve transition services for CYSHCN. As reported earlier 82% of CYSHCN report having received no transition services. When adjusted for age and semantics, many more do report having actually received these services (28-56%, depending on the element), and the CCSHCN cohort does report a significantly higher frequency of services than the non-CCSHCN cohort however, this area is targeted for improvement over the next five years.

a. NEW State Performance Measure #08: Percent to which CCSHCN transition action plan is implemented. Source: CCSHCN CUP (Patient Health Information System).

b. NPM #06: The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.
Through this process, CCSHCN utilized staff of the Healthy and Ready to Work National Resource Center to provide a national perspective on SPMs in designing the transition measure with an eye towards developing infrastructure. Using Hawaii's SPM as a model, CCHSCN has developed its own transition action plan as detailed in the Needs Assessment document.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	98	99	99.2	99.5	99.8
Annual Indicator	97.6	98.6	99.2	99.7	99.9
Numerator	526	725	860	965	960
Denominator	539	735	867	968	961
Data Source		KY Newborn Screening Database	KY Newborn Screening Database	KY Newborn Screening Database	KY Newborn Screening database
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	99.9	99.9	99.9	100	100

Notes - 2011
2011 data is prelminary and numbers could change.

Notes - 2010
2010 data is preliminary and numbers could change.

Notes - 2009
2009 data is preliminary and numbers could change.

a. Last Year's Accomplishments

In 2011, NBS staff continued working with hospitals in continuing development and implementation of the quality assurance process mandated by state regulation. NBS developed a protocol template to assist them in developing their own plan with greater ease. Approximately forty percent (40%) of all Kentucky birthing hospitals are compliant in updating their quality assurance plan in 2011. This will remain a focus of the NBS program throughout 2012.

Collaboration with birthing hospitals continues in the analysis of the timeliness of both specimen collection and submission to the state lab for testing. Time of specimen collection to receipt by the state lab was evaluated and NBS staff worked with facilities whose submissions where greater than seven (7) days to improve their collection and mailing processes. Analysis of the 2010 data for timeliness from specimen collection to receipt of specimen showed that the 2010 average is 4.48 days. Preliminary 2011 data equaled 4.36 days showing improvement in the overall process.

NBS staff also assisted facilities in the quality assurance process by tracking possible missed newborn screening tests. The Vital Statistics system is used to generate a report of birth certificates received versus the KY-CHILD system used by birthing hospitals. That information is then compared to screens received by the state lab. By accessing those three systems, we can identify documenting those with no screen collected. Any discrepancies found in these reports are investigated by contacting the specific birthing hospital for tracking and resolution.

In 2011, NBS continued participating as part of the Region 4 Genetics Collaborative in development of a database designed as a resource in establishing treatment protocols and producing a care notebook for parents of diagnosed infants.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Because of the QA protocol template developed in 2010, approximately 40% of all KY birthing hospitals were compliant in updating their QA plan in 2011.		X		X
2. Timeliness of specimen collection to receipt of specimen showed an improvement of the overall process from 4.48 days in 2010 to a preliminary 4.36 days for 2011.				X
3. NBS continued to participate as part of the Region 4 Genetics Collaborative in development of a database designed as a resource in establishing treatment protocols & producing a care notebook for parents of diagnosed infants.	X	X	X	X
4. Updates of educational materials for each of the original 47 disorders are available for health care providers & parents and are accessible online.	X		X	X
5. Kentucky began participating in a HRSA Regional Genetic & Newborn Screening collaborative Grant in 2012 aimed at long-term follow-up of identfied cases of Congenital Hypothyroidism involving parents and clinician follow-up regarding the experience, e	X	X	X	X
6. Kentucky KBSR was awarded a continuation grant by CDC to expand surveillance & integrate positively identified infants into both the KBSR and system for long-term tracking & referral to early intervention services.	X	X	X	X
7. Kentucky will be beginning the pilot of newborn screening testing for Critical Congenital Heart Defects in 2012, anticipating full implementation by January 1, 2013.	X	X	X	X

8. A web-based access to newborn screening results will be available to physicians by the state laboratory this year.				X
9. Ky state laboratory is researching the addition of testing for Severe Combined-Immunodeficiency to begin the project in 2013.				X
10.				

b. Current Activities
The program maintains updates for the original 47 disorders, informational fact sheets and resources for health care providers and parents. Education materials are found on the website http://chfs.ky.gov/dph/mch/ecd/newbornscreening.htm.

The state laboratory performs second tier tests for Cystic Fibrosis on the newborn screen including DNA testing on presumptive positive screens.

In 2012, KY received a HRSA Regional Genetic and Newborn Screening Collaborative Grant in Region aimed at long-term follow-up of identified cases of Congenital Hypothyroidism. This initiative involves parent and clinician follow-up regarding their newborn screening experience, education received, adherence to medication regime and developmental outcomes for positive cases from 2007.
A continuation grant awarded by the CDC was received by KBSR in 2011 to expand surveillance and integrate positively identified infants into the KBSR system for long-term tracking and for referral to early intervention services. A web-based database is in development for KBSR.

In 2012, work continues to provide education to reduce the number of refused newborn screens; assist hospitals develop comprehensive newborn screening protocols to decrease the occurrence of babies being discharged without newborn screening collected; improve time of specimen collection to submission to laboratory for testing; and develop methods for referring newly diagnosed infants to early intervention services for evaluation.

c. Plan for the Coming Year
A copy of each hospital's NBS protocol will be required on an annual basis. If the submitted protocol is determined inadequate, NBS will work with the hospital in developing a quality process to assure that all babies born at their facility receive a newborn screen before hospital discharge.

A 5-year report will be developed showing the number of infants diagnosed via the newborn screening expansion.

Monthly, quarterly, and annual reports will be enhanced to improve accuracy and time management for internal and laboratory staff.

Kentucky will be beginning the pilot stage of newborn screening testing for Critical Congenital Heart Defects (CCHD) in 2012 and anticipates full implementation expected by January 1, 2013. This involves collaboration with the University of Kentucky and the University of Louisville pediatric cardiologists, birthing hospitals, primary care providers, and parents. Development of interactive hospital training modules and educational materials for both primary care providers and parents is underway. Every child born in Kentucky will receive pulse oximetry testing prior to hospital discharge to identify possible CCHD and expedite diagnosis and treatment that could prove life-saving.

The Newborn Screening Program at DPH will be handling this program from pilot, training, expansion, implementation, and referral to pediatric cardiology and QA. Changes to our case management system are in progress to enable reporting, collection and analysis of all CCHD testing data. All confirmed cases will be reported to the Kentucky Birth Surveillance System and

to the First Steps Program for early childhood development intervention evaluation.

Implementation of web-based access for physicians to obtain newborn screening results has been implemented and we plan to roll out the program to all birthing hospitals by early 2013. Kentucky is researching the addition of testing for Severe Combined-Immunodeficiency (SCID). The state laboratory is actively researching equipment and the methodology to begin this project in 2013.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**54653**					
Reporting Year:	**2011**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	54653	100.0	10	7	7	100.0
Congenital Hypothyroidism (Classical)	54653	100.0	316	38	38	100.0
Galactosemia (Classical)	54653	100.0	70	4	4	100.0
Sickle Cell Disease	54653	100.0	8	7	7	100.0
Biotinidase Deficiency	54653	100.0	92	19	19	100.0
Congenital Adrenal Hyperplasia	54653	100.0	98	4	4	100.0
Cystic Fibrosis	54653	100.0	94	12	12	100.0
Homocystinuria	54653	100.0	1	0	0	
Maple Syrup Urine Disease	54653	100.0	2	0	0	
Hyperphenylalaninemia	54653	100.0	0	0	0	
beta-ketothiolase deficiency	54653	100.0	2	0	0	
Tyrosinemia Type I	54653	100.0	1	0	0	
Very Long-Chain Acyl-CoA Dehydrogenase Deficiency	54653	100.0	28	1	1	100.0
Tyrosinemia Type II	54653	100.0	8	0	0	
Argininemia	54653	100.0	1	0	0	
Argininosuccinic Acidemia	54653	100.0	7	0	0	
Hypermethioninemia	54653	100.0	0	0	0	
Isovaleric Acidemia	54653	100.0	5	0	0	

Methylmalonic Acidemia	54653	100.0	0	0	0	
Propionic Acidemia	54653	100.0	1	0	0	
Carnitine Uptake Defect	54653	100.0	20	0	0	
3-Methylcrotonyl-CoA Carboxylase Deficiency	54653	100.0	21	1	1	100.0
Methylmalonic acidemia (Cbl A,B)	54653	100.0	14	5	5	100.0
Multiple Carboxylase Deficiency	54653	100.0	3	0	0	
2-Methylbutyryl-CoA Dehydrogenase Deficiency	54653	100.0	3	0	0	
Trifunctional Protein Deficiency	54653	100.0	1	0	0	
Glutaric Acidemia Type I	54653	100.0	21	0	0	
Isobutyryl-CoA Dehydrogenase Deficiency	54653	100.0	3	1	1	100.0
Glutaric Acidemia Type II	54653	100.0	5	0	0	
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	54653	100.0	38	6	6	100.0
Long-Chain L-3-Hydroxy Acyl-CoA Dehydrogenase Deficiency	54653	100.0	7	2	2	100.0
3-Hydroxy 3-Methyl Glutaric Aciduria	54653	100.0	3	0	0	
Short-Chain Acyl-CoA Dehydrogenase Deficiency	54653	100.0	25	2	2	100.0
Malonic acidemia	54653	100.0	0	0	0	
Carnitine Acylcarnitine Translocase Deficiency	54653	100.0	0	0	0	
Methylmalonic acidemia (Cbl C,D)	54653	100.0	1	1	1	100.0
Citrullinemia Type 1	54653	100.0	2	0	0	
Citrullinemia Type 2	54653	100.0	0	0	0	
Non-ketotic Hyperglycinemia	54653	100.0	1	0	0	
Tyrosinemia Type III	54653	100.0	1	0	0	
Carnitine palmitoyl transferase deficiency I	54653	100.0	2	0	0	
Carnitine palmitoyl transferase deficiency II	54653	100.0	4	0	0	
2-Methyl-3-hydroxybutyric aciduria	54653	100.0	0	0	0	
3-Methylglutaconic aciduria	54653	100.0	3	0	0	
Ethylmalonic	54653	100.0	2	0	0	

encephalopathy						
Sickle hemoglobin-C disease	54653	100.0	22	1	1	100.0
Sickle cell S-ß thalassemia	54653	100.0	5	1	1	100.0
Various Hemoglobinopathies (includes Hb E)	54653	100.0	17	8	8	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	67	68	69	91	97
Annual Indicator	64.1	62.5	87.8	96.8	97.0
Numerator	5261	3999	431	1800	3695
Denominator	8206	6398	491	1860	3810
Data Source		CCSHCN Database (FY 08)	CCSHCN Family/Consumer Survey #11 & 11a	See field notes/CCSHCN Clinic Comment Cards	CCSHCN Clinic Comment Cards
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	97	97	97	97	97

Notes - 2011
NPM 2:
Information derived from averaging responses to two (2) questions on CCSHCN clinic comment cards:

1. Those responding "yes" to the question "Do you feel that CCSHCN staff listen to you regarding your care (or your child's care)?" (96.4%); and
2. Those responding "very satisfied" or "satisfied" to the question "How satisfied are you with the care you (or your child) received today at CCSHCN?" (97.6%)
Average of 96.4% & 97.6% = 97%

Notes - 2009
2009 Data from CCSHCN Needs Assessment Consumer/Family Survey - average of 2 separate questions addressing satisfaction and partnership in making decisions. Responses filtered to CCSHCN respondents.

a. Last Year's Accomplishments
While Kentucky uses state-generated data to report progress on this National Performance Measure, CCSHCN notes that in the 2009/2010 National Survey of Children with Special Health Care Needs (NSCSHCN), Kentucky's families reported being partners in shared decision-making at a higher level (73.6%) than the national average (70.3%). This was also the case in the previous survey (2005/2006). Among CCSHCN enrollees, satisfaction and family participation remains high.

Through care coordination, CCSHCN staff assist and enable CYSHCN to obtain family-centered, culturally-sensitive, developmentally-appropriate services. Staff actively engage in a partnership with families and providers to individualize care, provide support, and obtain the best possible outcomes. To measure the effectiveness of this collaboration and the direct care experience, the agency continued to use a structured comment card protocol in all onsite clinics. The comment cards provide instant and timely input from families on an ongoing basis. The "mini-survey" is comprised of 5 questions (intentionally kept brief to encourage participation), but two separate questions measure satisfaction and listening -- a key element of partnership. The resulting numbers are averaged to obtain the annual indicator for the Performance Measure.

Past the direct service level, CCSHCN strives to weave the voices of both parents and CYSHCN into the fabric of operations, so that families are involved in policy decisions that affect them, and are partners in decisionmaking. The Parent Advisory Council (PAC) continued to be a vital and relevant group, providing input on a variety of CCSHCN matters, and guidance for the KY Family to Family Health Information Centers (F2F). During the past year, topics of PAC discussion included development of a parent tipsheet on requesting educational accommodations, the CCSHCN comment card survey, and discussion topics for the agency Facebook page. The tipsheet represents a companion piece to one developed during the previous year by members of the Youth Advisory Council (YAC). YAC continued to meet regularly and, outside of meetings, some YAC members participated in CCSHCN activities (such as the Louisville regional holiday party for patients and families), and, as a result of an article published in the statewide transitions newsletter, the chair presented about transition at the Kentucky Department of Education Summer Awards Brunch (audience: high school teachers and college disability coordinators), a presentation which was well-received. YAC members provided input on a variety of CCSHCN matters, such as those pertaining to agency efforts to improve transition services for youth (see SPM #8). This feedback has directly impacted service delivery.

Family consultants attended multiple trainings and CCSHCN staff participated in community events (e.g. Transition Fairs), partnering with professionals and parents and providing opportunities to take back information on available services to CCSHCN patients, and to educate on CCSHCN services available to the community. Family consultants played active roles on internal CCSHCN work groups (e.g. Healthy Weight and Transition Action Plan) and external committees (e.g. Regional Interagency Transition Teams), lending a family perspective to policy-makers. Family consultants and "family scholars" attended the AMCHP/Family Voices conferences in order to acquire valuable information about national trends in maternal and child health topics and build relevant skills.

Under the guidance of F2F, parents provided one on one assistance to nearly 1200 families and over 130 professionals during the reporting period to build the capacity of parents to advocate for their children's needs. 93.5% of families surveyed by Family to Family reported that the assistance/information/resources received was useful in helping them work with professionals to make decisions about their child's health care. Key Family to Family activities included: Youth volunteers with SHCN themselves serving as mentors in CCSHCN clinics, resource material on topical issues (such as Affordable Care Act, special education, special needs trusts, EPSDT, medicaid waiver, accessing durable medical equipment, "504" plans), participation in genetic collaborative and collaborative for medical home, and facilitation of regional focus groups.
An attachment is included in this section. IVC_NPM02_Last Year's Accomplishments

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CCSHCN Parent Advisory Council meets regularly and is open to all parents of Kentucky CSHCN. Transportation expenses are reimbursed.		X		X
2. CCSHCN Youth Advisory Council meets regularly and is open to all Kentucky CYSHCN. Transportation expenses are reimbursed.		X		X
3. CCSHCN acts under the direction of a Board of Commissioners, as well as program-specific advisory boards.		X		X
4. CCSHCN employs parents of CSHCN as family consultants.		X		
5. Interpreters are available for families of CSHCN who are limited in English proficiency.		X		
6. Information about CCSHCN and CSHCN services are available, in English and Spanish, on the CCSHCN website.	X	X	X	X
7. CCSHCN clinic survey measures satisfaction and other key elements of success.		X		X
8.				
9.				
10.				

b. Current Activities
CCSHCN evaluates satisfaction through comment cards and calls to the consumer comment line. It is the agency's intention to encourage families to discuss with care coordinators and providers their child's treatment and to provide a friendly environment in which it is easy to ask questions or raise concerns.

As the chief complaint has been a long wait time to see physicians, CCSHCN has begun to analyze clinic and scheduling processes to determine an appropriate scheduling model that will maintain physician utilization while decreasing patient wait time for services. Two offices are currently implementing new appointment scheduling systems based on their unique clinic environmental characteristics.

CCSHCN's Facebook page expands communication with patients and unserved CYSHCN. Updates are more frequent than in years past; through publicity and familiarity, it is hoped that a more interactive relationship with CYSHCN may be cultivated.

Current activities for F2F include expanding the network of parent consultants and working with families and professionals directly to assist in problem-solving. Other activities include further focus groups to gauge the needs of parents. Staff continue to send packets of informational resources to parents of newly-diagnosed infants with permanent hearing loss and make follow-up

calls to offer assistance. Co-directors have also been instrumental in orienting CCSHCN's new State Implementation Grant administrator to the family experience.

c. Plan for the Coming Year

CCSHCN relies on its Board of Commissioners, PAC and YAC for guidance on how to best address the concerns of the special needs population. Board members are often parents of special needs children or practitioners with extensive expertise treating this population, including early intervention, the Kentucky Deaf-Blind Project, and a protection/advocacy program for the disabled. Such diversity allows CCSHCN to receive feedback from a variety of external sources regarding the public perception of CCSHCN programs.

CCSHCN will continue to enhance and improve relationships with managed care organizations, and identify access to care issues for CYSHCN population in Kentucky.

CCSHCN will continue to monitor results of surveys to ensure continued satisfaction among families of CYSHCN.

Through the strategic planning process and activities of the State Implementation/D70 grant, CCSHCN will research ways to impact CYSHCN who do not currently receive services from CCSHCN.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	92	93	93	94	94
Annual Indicator	91.3	92.0	91.9	94.6	93.7
Numerator	7618	7724	7320	7348	7387
Denominator	8343	8393	7964	7769	7885
Data Source		CCSHCN Database (FY 08)	CCSHCN CUP Information System	CCSHCN CUP Information System	CCSHCN CUP Information System
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	95	95	95	95	95

Notes - 2011
NPM 3
Numerator (KY 0-18 with Primary Care Physician)
Denominator (KY 0-18)

Notes - 2009
Data derived from CCSHCN CUP information system

a. Last Year's Accomplishments
The Thomas H. Pinkstaff Medical Home Clinic, a collaboration with the University of Kentucky and housed in the Lexington CCSHCN office, continues to provide primary care and care coordination for children involved with Kentucky's child welfare system and other CYSHCN. Enrollment during the reporting period continued to increase significantly (almost 1700 visits during the reporting year, up from 1300 the previous year). The program is a well established part of CCSHCN's array of services.

Staff participate with the Region 4 Genetics Collaborative, which has a core mission to assure that CYSHCN receive comprehensive care in a medical home environment. Through collaboration with Region 4, informational handouts and guides have been incorporated into family consultants' educational resources to ensure families become familiar with the principles of the medical home through a variety of methods. CYSHCN families are educated about what a medical home offers: accessible, continuous, comprehensive, coordinated, compassionate, and culturally effective family centered care. Tip sheets are also available to provide guidance regarding choosing and working with a doctor, preparing for and participating in a doctor's appointment, what care coordination and culturally effective care look like, as well as continuous care while transitioning to adult care.

As is mentioned elsewhere, Kentucky received and began work in earnest on a State Implementation/D70 grant which has as a goal of developing partnerships to ensure that CYSHCN have the resources and assistance needed for ongoing comprehensive care within a medical home. CCSHCN has convened a steering committee of partners (including the American Academy of Pediatrics Kentucky Chapter medical home champion) charged with overseeing these activities. Impacts desired include outreach to previously unidentified CYSHCN, a self-sustaining comprehensive transition model, and access to resources that assist CYSHCN in becoming active partners who transition successfully into adult medical homes.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Primary care physicians are identified for each child and documented in "CUP" database.				X
2. CCSHCN provides medical specialty care in collaboration with child's medical home.	X			
3. Children are able to see multiple specialists in one visit to clinic.	X			
4. Foster Care Support collaborations with DCBS allows for the coordination of medical services for children in the foster care system.	X	X		
5. The Medical Home Clinic in Lexington provides primary care for children in the foster care system who do not otherwise have a primary care physician.	X	X		
6.				

7.				
8.				
9.				
10.				

b. Current Activities
Twelve CCSHCN offices throughout the state continue to provide on-site multidisciplinary specialty clinics. CCSHCN strives to ensure that all patients are active with a primary care physician by verifying that primary care services are received at each clinic encounter. If primary care is not identified, the clinical staff attempts to connect the family with an appropriate provider within its community. To ensure continuity of care, specialty clinic dictation and medical plans of care are shared with the patient's primary care physician in accordance with HIPAA guidelines after each clinic visit.

CCSHCN registered nurses and social workers provide comprehensive care coordination. These services include education, and developmentally appropriate transition services mindful of lifelong health goals and uninterrupted services into adulthood.

The CCSHCN foster care program continues to collaborate with the state's child welfare agency to support the medical home model by ensuring that ongoing, preventative health services are addressed for the foster care population and those at risk of placement. Nurse consultants integrate into practice an assessment and communicate with social services workers about the need for a medical home on all consults completed. Nurse consultants support the medical home concept by providing health education to youth, foster parents, and social service workers, as well as facilitate referrals to pediatric and specialty health care.

c. Plan for the Coming Year
CCSHCN staff continue to work with families to ensure that CYSHCN have medical home-type environments. A further emphasis on follow-up is planned on referrals.

As standards of practice are established for care coordination, clinical staff will receive education to enhance and support their role in the medical home model. Further, cultural competence awareness is being organized to provide a more culturally aware workforce.

One of the objectives of the State Implementation/D70 grant (Kentucky Integrated Services for CYSHCN, or "KISC") is implementing the Medical Home concept. In conjunction with the KISC Steering Committee and Kosair Children's Hospital Bridges to the Future transition program, CCSHCN is actively working on workshops and community outreach to educate physicians who are unfamiliar with the Medical Home concept. As KISC moves forward, CCSHCN is working to build a network of adult physicians committed to providing care to transition age CYSHCN to improve the access of care as CYSHCN move to an adult health care model. KISC is conducting outreach to encourage adult providers to embrace the medical home concept. CCSHCN's development of a physician portal will enhance the referral pathways for participating physicians as well increase access to quality and comprehensive care for CYSHCN.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	93	99	99	99	99

Annual Indicator	92.4	90.9	93.1	95.8	95.7
Numerator	8125	7626	7417	7444	7547
Denominator	8791	8393	7964	7769	7885
Data Source		CCSHCN Annual Report for FY 08 and CCSHCN Database	CUP Database	CUP Database	CUP Database
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	96	96	96	96	96

Notes - 2011
NPM 4:
Numerator: KY CCSHCN enrollees 0-18 w/private or public insurance
Denominator: KY CCSHCN enrolleed 0-18

a. Last Year's Accomplishments
CCSHCN has continued to maintain a low uninsured rate by moving to a centralized approach of financial eligibility processing with a team who specializes in this function. Insurance status continues to be verified on patients who are scheduled for upcoming services but now when a lapse in insurance is identified, the Intake and Eligibility Branch is immediately notified and steps are promptly initiated to restore coverage.

Undocumented aliens, Amish and young adults who are out of school and are over the age of 18 years old, continued to represent the majority of the uninsured population served. CCSHCN provided financial support and assistance for high cost conditions and low income populations to reduce barriers and ensure that needed services were acquired in a timely fashion. CCSHCN social work staff have become proficient in advocating and securing temporary Medicaid coverage for those undocumented aliens requiring surgeries which prevent future medical deficits and/or emergencies resulting from the lack of needed treatment.

Through a partnership with Patient Services Inc. (PSI), CCSHCN was able to continue the provision of insurance case management for hemophilia and cystic fibrosis patients who are over the age of 18 and are uninsured or at risk of losing their insurance coverage. A review of the process was conducted to identify, 1) how long the process took from point of referral to the securing private insurance, 2) what the reasons were for patients not completing the process of securing insurance coverage, and 3) what adjustments could be made to make the program more successful.

As a result of our review and findings, we removed the initial financial barrier to application and incorporated the special application required for this program into our centralized intake and eligibility process and made it a requirement for participation. This team, through their contact and relationship with patient, counsels about the financial benefits, familiarizes the patient with the partnership, and ensures the application is correctly completed. Once received, they directly

submit the information to PSI for processing. CCSHCN also implemented a feedback loop so that additional intervention and assistance could be provided should the need arise. There was a slight increase in the numbers who gained assistance with health insurance but we hope to improve this further.

The expansion of the Medicaid managed care system in Kentucky, from one to four (4) organizations in the fall of 2011 has had a dramatic impact on the provision of care for CYSHCN. Approximately 15-20% of Kentucky's total Medicaid population, which resides in the sixteen (16) counties surrounding the Louisville metropolitan area, has been served by a managed care organization (MCO) which was originally created as a partnership by local stakeholders. The statewide expansion, which was bid out, awarded and executed in just over 6 months, currently lacks the breadth of contracted specialty providers required and willing to serve the population of CYSHCN. CCSHCN has entered into contracts with each MCO and has been working with and advising them on the obstacles we are encountering with service delivery.

Providers have expressed concern over contracting language, reimbursement rates, prior authorization requirements and increased overhead costs. Consumers have experienced confusion and frustration when the providers with whom they are currently connected are not participating with their newly assigned networks. Much CCSHCN staff time is spent navigating separate and unique MCO rules, forms, and networks, attempting to assure that CYSHCN receive authorized services they need from covered providers who participate in their networks. Educating patients and families on the new requirements and intricacies of their new insurance plans has made care coordination in this environment a real challenge.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CCSHCN staff document and the insurance status in the electronic data system.				X
2. CCSHCN educates families about their insurance coverage and seeks additional sources of payment for services for which the family may qualify.		X	X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CCSHCN staff have had to become experts in patching together coverage for CYSHCN in various gaps and recognize that there are no one-size-fits-all insurance solutions. CCSHCN is investigating how to maximize utilization of the Kentucky's pre-existing condition insurance plan (PCIP). PSI has been successful in accessing this resource for the designated pool of patients they support but CCSHCN is looking for additional ways to identify and assist others who may be eligible. Kentucky's PCIP enrollment has been steadily increasing during the reporting year and has been helpful to many waiting for key provisions of the Affordable Care Act to go into effect. A state-administered high-risk pool also exists but the cost for these plans are often prohibitive, while the PCIP rates are very reasonable.

CCSHCN has sought out and found community partners who are serving the needs of the

uninsured and have begun discussions on how we might work coordinate our activities to support these patients and families. We hope to accomplish this through staff education, referrals and parent advocates.

c. Plan for the Coming Year

For the population of uninsured CYSHCN 18-21, the State Implementation/D70 grant team will be developing a plan for providing health care resources, and distributing helpful resources to this population. CCSHCN will be keeping apprised of new developments and information regarding federal health care reform and the implications for CYSHCN. In addition to traditional methods of dissemination of resources, a greater emphasis on using social media, particularly through CCSHCN's Facebook page, is planned, so that more stakeholders may be educated about solutions that may be available.

As CCSHCN continues to make efforts to push down low uninsured rates for patients where public insurance is an option, it recognizes that there are still pockets particularly related to underinsurance. The current trend is a shift of financial risk and burden of health care from the insurance carrier to the subscribers has resulted in a significant number of people who are underinsured. With increased deductibles and co-insurance amounts, they simply do not the additional financial resources, over and above the premium costs, to pay the rising costs required for treatment. The insurance plans are shifting from having set, moderate, easy-to-anticipate copayment amounts towards high deductible plans (HDPs) and co-insurance percentages with very high splits; some of them moving as high as 50-50%.

Quantifying benefit levels poses quite a challenge due to the sheer number of plan offerings and the variety of nuances contained in each. Finding a methodology for setting criteria to measure and assess the level of underinsurance will be the challenge for this next year. Once the extent of this barrier is defined, CCSHCN will evaluate how to interface to ensure that timely medical care and interventions occur. CCSHCN intends to establish criteria for measuring the extent of need for those with insurance and then make projections about the programs ability to offer financial and community support to those most in need. Exploration of greater use of Medicaid waiver programs for very medically involved patients may be in order.

CCSHCN will be continuing its efforts to solidify relationships and opportunities with community partners through formalized Memoranda of Understanding/Agreement.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	93	93	96	97	98
Annual Indicator	92.9	95.5	95.9	97.4	96.4
Numerator	7749	7928	7558	7564	7603
Denominator	8343	8304	7880	7769	7885
Data Source		CCSHCN Database (FY 08)	CCSHCN CUP Information System	CCSHCN CUP Information System	CCSHCN CUP Information System
Check this box if you					

cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	97	97	97	97	97

Notes - 2011
NPM 5:
Numerator: KY CCSHCN enrollees 0-18 with specified note type
Denominator KY CCSHCN enrollees 0-18

Notes - 2009
Data derived from CCSHCN CUP information system.

a. Last Year's Accomplishments
Despite the fact that ease of use of services represented a strength for the state in the previous needs assessment, results of the 2009/2010 National Survey of Children with Special Health Care Needs showed that 36.2% of Kentucky CYSHCN did not meet criteria for MCHB Outcome 5 - i.e., they reported difficulties or frustration in obtaining community based services that are easy to use. This represents a figure slightly above the national average of 34.9%. In keeping with the practice of several years, CCSHCN reports progress on this indicator with state data - specifically, information on coordinated services received by CYSHCN enrolled in the CCSHCN program. While the numbers remain high, they do not meet the annual objective. No matter how the measure is quantified, CCSHCN recognizes that facilitating a more integrated service system is an important goal.

Kentucky's CCSHCN traditional program fills a gap in direct services by providing specialty clinics in regional offices across the state and recruiting a network of contracted providers willing to treat CYSHCN. Beyond the provision of medical services, though, CCSHCN staff assist families of CYSHCN to navigate existing systems of care in many ways - through the care coordination of registered nurses, brokering of services by social workers, nursing consultation by staff outstationed in child welfare offices (see below), and referrals/services provided by a variety of augmentative staff. CCSHCN works to advance integrated care systems for CYSHCN through collaborations exploring interagency partnerships, and by maintaining an intranet site designed to educate staff about community resources which can assist families. CCSHCN also maintains internet and Facebook sites, which are used to provide information.

Family to Family Health Information Centers (F2F) represent a key strategy toward assisting with education, accessibility of services, and navigation of community based services. F2F continues to work one on one with families to educate as to how community based services are organized and how they can be accessed. F2F also worked with those interested in improving the delivery of services by equipping them with the tools and information they needed to advocate for needed changes. During the reporting period, F2F engaged almost 1300 families on resources available based on families' needs. When measuring impact, 96.7% of families surveyed by F2F about their interactions reported that the support/information/resources received was helpful in building

family confidence in getting their child the health care and services he/she needs. 83.9% felt that the assistance/information/resources was useful in helping the family find and/or learn about community services. In addition to guiding individual families to services through a network of parent mentors and youth volunteers, F2F worked with other entities (such as Kentucky Special Parent Involvement Network and the Kentucky Commission on the Deaf and Hard of Hearing) to increase their expertise in specific services and resources available and then disseminate information. Support parents have attended conferences, workshops, and school events throughout the state to disseminate information with families of CYSHCN, including those enrolled in CCSHCN and those outside CCSHCN.

CCSHCN seeks to collaborate with community partnerships to coordinate activities and services. Staff are actively involved in the Kentucky Interagency Transition Council for Persons with Disabilities and 11 Regional Interagency Transition Teams across the state. Participation in these and similar activities enable CCSHCN to connect and share information with CYSHCN, their families, and other service providers. CCSHCN strives to be a visible and relevant contributor to the local and state service systems and last year participated in a variety of multidisciplinary groups, such as Community Collaborations for Children, Safe Kids Coalitions, District Early Intervention Councils and local committees that support area charities and resources for low-income residents.

CCSHCN's Foster Care Support program provides individualized assistance through case-specific consultations with the child welfare staff, visits to "medically fragile" children in foster care, and primary care at the Medical Home Clinic. A goal of these programs is to make the health care system more navigable for CYSHCN in or at risk of state's care, child welfare workers and foster parents.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Families with children who require services from multiple specialists were scheduled to see multiple providers in one clinic visit.	X			
2. CCSHCN employs two parent consultants who educate families in the navigation of community-based service systems.		X	X	
3. CCSHCN staff partner with and participate on advisory boards and councils which are community-based, e.g. Regional Interagency Transition Team and First Steps.		X	X	
4. CCSHCN staff attend community organized events statewide to promote and distribute information about the agency and its services.		X	X	
5. CCSHCN offers materials in other languages, as well as seeks out resources for families that are culturally competent.		X	X	X
6. CCSHCN utilizes a voice mail system with a separate voice mailbox with information in Spanish. Staff with the Cabinet for Health and Family Services translate the messages for staff.		X	X	
7. CCSHCN provides consultative nursing services to Department for Community Based Services social work staff for children in the foster care system.		X		
8.				
9.				
10.				

b. Current Activities

Ease of use is currently being significantly affected by new Medicaid managed care organizations' delay of payments - which impacts each MCO provider base and networks.

It is a goal of CCSHCN to ensure that all CYSHCN, have access to providers and coordinated support services they need. The agency is examining where in the state CYSHCN reside, and how more can be reached -- whether by CCSHCN or other providers. CCSHCN leadership is communicating with other providers and planning ways to better outreach to large concentrations of CYSHCN. Staff moves forward toward the objectives of the D70 grant, which includes developing partnerships to ensure CYSHCN have the resources and assistance needed for care and support. Representatives from several major healthcare organizations are contributing their time to the project's steering committee. The Bridges to the Future program, funded by the grant and administered by the Kosair Children's Hospital, marks a key community partnership in which services are available to CYSHCN not served by CCSHCN.

CCSHCN is identifying and reconnecting with common partners to define our collective roles and contributions toward improving the infrastructure for CYSHCN.

CCSHCN maintains and monitors a dedicated consumer call line, through which CCSHCN enrollees or members of the general public may be connected with a service or resource or be assisted with an issue

c. Plan for the Coming Year
CCSHCN is considering adjusting data collection efforts to better measure ease of use of community based services for CYSHCN. Technical assistance may be requested on how to improve collection efforts so that the agency ensures validity in measuring and reporting on this NPM.

CCSHCN's F2F will continue to work with families and seek their input on their needs and provide training to assist, and will develop additional materials that are easy for families to understand regarding how to navigate community based services. F2F is now seeking advanced matching software.

As part of the agency transition plan (see SPM 8), CCSHCN will be working to improve how it acquaints patients and their family members with community based services to help make it easier for families to access these services.

As the recipient of a State Implementation Grant for Systems of Services for Children and Youth with Special Health Care Needs, CCSHCN has as objectives working with community partners and building relationships to minimize duplication of effort while improving outcomes for CYSHCN. CCSHCN continues to add providers to its network, especially in rural areas, while continuing to work with other partners to expand services to a wider base of CYSHCN than the agency has traditionally served. A focus will be on closing loops and evaluating services and referral patterns - and following up with families who did not qualify for ongoing services directly provided by CCSHCN, to ensure that they found and are accessing needed services.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and	2007	2008	2009	2010	2011

Performance Data					
Annual Performance Objective	53	30	53	54	67
Annual Indicator	55.4	62.4	61.0	59.5	61.7
Numerator	897	902	831	1366	1372
Denominator	1618	1445	1362	2297	2224
Data Source		CCSHCN Database (FY 08)	CCSHCN CUP Information System	See field notes/CUP & Comment Cards	CUP & Comment Cards
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	65	66	67	68	69

Notes - 2011
NPM 6:
Information derived from averaging CUP (information system) data query with two (2) questions on CCSHCN comment cards:
1. (CUP) KY children ages 14-18 with plans for an adult health care provider; (56.4%)
2. Those responding "becoming as independent as possible" to "Has CCSHCN staff ever discussed the following topics with you (or your child)?" (73.1%); and
3. Those responding "getting the education and skills needed for a job" to "Has CCSHCN staff ever discussed the following topics with you (or your child)?" (65.1%)
Average of sum of numerators divided by sum of denominators = 61.7%

Notes - 2009
Data derived from CCSHCN CUP information system.

a. Last Year's Accomplishments
CCSHCN notes that state-generated transition scores have inched up, but improvement is still needed. Additionally, Kentucky's score (37.1%) on the 2009/2010 National Survey of Children with Special Health Care Needs represents a decrease from the 2005/2006 survey score (42.8%), and is now below the national average (40%). Through work on this NPM and SPM 8, CCSHCN has created a plan to increase agency capacity regarding transitions. Transition for CYSHCN as they move to adult services is an integral element of the discussion and planning that staff engage in with enrollees and their families. Outside of clinics, CCSHCN did outreach to previously unidentified CYSHCN to provide resources and support during this critical period through collaborations in activities such as Disability Mentoring Day and local and regional job fairs.

During the past year, the agency has been piloting a revised transition checklist in several sites. The updates are intended to simplify the checklist and increase active patient and family

participation in the discussion. Rather than staff completing a computer-based checklist, the process now is guided by the interest areas of CYSHCN and families which are outlined on a paper form, as areas of focus are selected. Using this method, families are able to initiate the discussion, and the planning is more individualized and relevant to the CYSHCN's needs.

CCSHCN has been awarded a State Implementation/D70 Grant for its new "Kentucky Integrated Services for CYSHCN (KISC)" program, which is moving forward to seek out and develop community and state partnerships supporting the expansion of transition initiatives. Specific deliverables include educational workshops to empower youth to take control over their own medical condition, brochures and other materials to help youths become medically independent and self-sufficient through the transition process, and working with pediatricians to disseminate materials at developmentally appropriate times. Through grant activities, it is hoped that statewide, 2000 or more previously unidentified CYSHCN will receive services and resources necessary to make transitions to all aspects of adult life.

Involvement in the Kentucky Interagency Transition Council for Persons with Disabilities and the 11 Regional Interagency Transition Teams (RITT) across the state, which includes participating in transition information fairs, job/transition fairs & Disability Mentoring Day activities, assist CYSHCN to job shadow and explore employment. Being a part of these types of activities allows CCSHCN and F2F support parents to share information and encourage CYSHCN and their families to pursue work and independence as an adult.

The CCSHCN Transition Administrator serves as Chair of the Kentucky Statewide Council for Vocational Rehabilitation and on the Board of Directors for the Center for Accessible Living. Vocational Rehabilitation and Independent Living Centers are important links for transitioning youth to post-secondary education, work and independence. The Transition Administrator brings back first-hand information to CCSHCN staff and can serve as a liaison between CCSHCN and these agencies. The Transition Administrator attended both the spring and fall Council of State Administrators of Vocational Rehabilitation conferences where he gained knowledge of current initiatives and programs regarding vocational rehabilitation.

CCSHCN's age-specific transition surveys for youth were initiated during the previous year. Letters soliciting feedback on the surveys have been revised due to low response, and the survey will be opened up for input from a greater pool of CYSHCN, once technological adjustments are made. The goal is for CCSHCN to be able to gauge CYSHCN knowledge about various aspects of transitions, and use survey results to better provide such services for CYSHCN and their families.

The CCSHCN Youth Advisory Committee (YAC) developed a tipsheet on requesting accommodations in school and improving self-advocacy skills, and the Parent Advisory developed a tipsheet for parents, which supplements. These documents were distributed to CCSHCN staff to share with CYSHCN and their families. In followup, the YAC suggested that CCSHCN staff could develop some informational sheets for selected conditions, to help patients better understand their disabilities. CCSHCN nurse administrators have developed several drafts, which are in the process of being reviewed by YAC.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CCSHCN staff utilize and update Transition Checklist. Information is documented in electronic data system. Items on checklist identify readiness to transition to adult life.		X		X
2. CCSHCN provides training and planning resources to members of the Youth Advisory Council; and solicits ideas for training needs.		X		X

3. CCSHCN provides training and planning resources to members of the Parent Advisory Council; and solicits ideas for training needs.		X		X
4. CCSHCN partners with other federal and state organizations which educate and support youth and adults in the transition process, such as the Office of Vocational Rehabilitation and Center for Accessible Living.		X	X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
CCSHCN now provides voter registration services. All 18 year-old CYSHCN enrolled receive letters and voting forms upon application to the program, reapplication, and change of address. CCSHCN staff are available to assist, and transmit forms to county clerks for processing. As part of the transitions discussion, staff are prompted to discuss in greater detail voter registration information as a means to help educate CYSHCN about their right to vote.

CCSHCN staff look for ways to address transition needs of unidentified CYSHCN in their respective communities and participate in events such as information fairs with local school districts and a variety of other agencies. CCSHCN continues to partner with transition liaisons from the state special education cooperatives.

The KISC program has convened a steering committee to serve as the guiding force for the D70 grant. Several potential grant activities for the upcoming year have been identified. All activities will increase community collaboration and sharing of resources used to assist transition age CYSHCN as they prepare and begin to transition into adult health care. Several partners have expressed a desire to work with CCSHCN to reduce duplication of services and maximize the use of the resources available within the state. KISC has developed a contract to support the Bridges to the Future transition program operated by Kosair Children's Hospital.

c. Plan for the Coming Year
CCSHCN will be using the revised transition checklist, and continuing to work with YAC, PAC, families, schools and other community partners to identify and address transition needs of CYSHCN during the coming year. To increase agency capacity, CCSHCN continues to work to achieve the goals detailed in SPM 8. KISC will continue implementation through the planned activities listed above.

CCSHCN will be analyzing processes so that the agency identifies when patients most need transition services and who can best provide them. It is hoped that a focused approach with set criteria will meet the greatest needs of the most CYSHCN, and that the right people are getting the right services when they need them.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	92	86	86	88	78
Annual Indicator	80.9	76.8	56	72.5	73
Numerator					
Denominator					
Data Source		CDC's NIP Survey	CDC's NIP Survey	CDC's NIP Survey	CDC's NIP Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	74	74	78	78	80

Notes - 2011
Numerator and denominator data are not available. Data is from the CDC NIP survey. Data is from 2010. The 4:3:1:3:3 series coverage is based on the original definition for this series. It is not recommended for comparison to years prior to 2009 because of the changes made in the way the HiB vaccine is now measured and the vaccine shortage that affected a large percent of children that were included in the 2009 and 2010 samples.

Notes - 2010
Numerator and denominator data are not available. Data is from the CDC NIP survey.

Notes - 2009
Numerator and denominator data are not available. Data is from the CDC NIP survey.

a. Last Year's Accomplishments
Within DPH, the Division of Epidemiology and Health Planning is the lead division for the Kentucky Immunization Program. Programs operated by the Title V agency and LHDs routinely assess immunization status. Immunizations are provided through the LHDs, private physicians, FQHCs, and school based health centers.

A child's immunization status is assessed and referrals are made at many points within the health, education and social service delivery system. Specific programs within the Division of MCH that effect this measure within preventive and primary services for children include the following: Regional Pediatrics Program; Child and Youth Project; Well Child Program; Health Access, Nurturing Development Services (HANDS); WIC; and Healthy Lifestyle Education.

As part of the Vaccines For Children (VFC) program, transaction data for 2011 indicates that KIP distributed 589,650 vaccine doses to public providers and 397,556 vaccine doses to private providers, for a total of 987,206 doses, for administration to Kentucky children aged 0 through 18 years of age. This is a slight decrease from 2010 transaction data showing distribution of a total of 1,170,446 doses. The following vaccines are distributed through KIP: diphtheria, tetanus, polio, Haemophilus influenzae type B, hepatitis A, hepatitis B, HPV, measles-mumps-rubella, meningococcal, pertussis, pneumococcal, rotavirus, and varicella. These vaccines are purchased using federal, state, and KIDS Now Tobacco Settlement funds. Transaction data cannot be extrapolated by age but is tracked closely by funding source in accordance with requirements

outlined in the Immunization Program federal grant.

Current NIS data (January- December 2010) indicates a coverage rate of 72.5 % (CI 6.2) for the 4:3:1:3:3:1 immunization series of diphtheria, tetanus, pertussis, polio, measles, mumps, rubella, Haemophilus influenzae type B, hepatitis B, and one or more doses of varicella vaccine for children 19 through 35 months of age. This is a slight decrease in the coverage rate for this series of vaccines compared to the previous data for 2009. This decrease is not significant and the confidence interval falls within the coverage rates reported in 2009. During site visits, KIP field staff not only perform assessments of immunization coverage in 19 through 35 month olds, but also provides technical assistance and education to providers and their staff regarding methods to reduce missed opportunities to vaccinate. KIP field staff tailor their educational efforts to the needs of each provider office in accordance with the updated AFIX Policy and Procedure Manual. At the 2010 National Immunization Conference, KIP received an award from CDC for this high coverage rate. KIP also received an award for most improved coverage rate for an improvement of 11.0% in coverage rate from 2005-2009.

NIS data reflects a sample of children in Kentucky, regardless of their participation in the VFC program, and is a more accurate reflection of coverage than KIP could provide. However, NIS data reflects a sample of immunization practices from January to December 2009 and does not provide coverage data for all immunizations provided by KIP.

KIP developed and implemented the use of an internally developed and CDC approved AFIX manual for use by the Immunization Field Staff as they conduct site visits. The AFIX workgroup met once per month in person and as needed in between meetings to develop the AFIX manual. It was pilot tested in 2009, field staff were trained in the use of the manual and it was successfully implemented in 2010. Currently the manual is being used as a guide for AFIX site visits. The manual is considered as a continuous improvement process for the KY immunization program.

The Department for Public Health's (DPH) Immunization Program was recognized for high immunization coverage levels for a childhood vaccination series by the federal Centers for Disease Control and Prevention (CDC) at the national 2012 Immunization Program Managers Meeting. Kentucky's childhood vaccination series coverage rate was approximately 80.6 percent in the last two quarters of 2010 and the first two quarters of 2011, compared to the national coverage rate of approximately 73.1 percent. KY was also recognized for improving childhood immunization coverage levels from 63.3 percent in 2007.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. KIP distributed 589,650 vaccine doses to public providers and 397,556 vaccine doses to private providers, for a total of 987,206 doses for administration to KY children 0 through 18 years of age in 2010.	X		X	
2. KIP distributes these vaccines annually: diphtheria, tetanus, polio, Haemophilus influenzae type B, hepatitis A, hepatitis B, HPV, measles-mumps-rubella, meningococcal, pertussis, pneumococcal, rotarius, and varicella.	X		X	
3. KIP field staff perform assessments of immunization coverage in 19-35 month olds as well as TA and education to providers and their staff regarding methods to reduce missed opportunities to vaccinate.		X		X
4. As a CQI process, KIP developed & implememnted the use of an internally developed and CDC approved AFIX manual for use by the Immunization Field Staff as they conduct site visits.				X
5. KIP is currently piloting a secure and confidential web-based		X		X

Immunization Registry used to identify pockets of need, consolidate records for individuals who do not have medical homes or who move, minimize vaccine administration errors & help measur				
6. KIP amended KY regulaton 902 KAR 2:060 governing the requirements for immunications for children & adolescents to add requirements for pneumococcal vaccine, varicella, tetanus, diphtheria, Tdap, and meningococcal vaccine.			X	X
7.				
8.				
9.				
10.				

b. Current Activities
KIP is developing a secure and confidential web-based Immunization Registry through a contract with Custom Data Processing (CDP). The registry will ensure that all persons within Kentucky are protected against vaccine-preventable diseases. It will be used to identify pockets of need, consolidate records for individuals who do not have a medical home or who move, minimize vaccine administration errors and help to measure the effectiveness immunization campaigns. In 2010, the Immunization Registry began its pilot phase in preparation for statewide roll-out, beginning with 2 private providers and 2 local health departments in the first pilot phase. The Immunization Registry Coordinator began collaboration with the developing Kentucky Health Information Exchange (KHIE) for the purpose of integration with KHIE.

In 2010, KIP amended 902 KAR 2:060, governing the requirements for immunizations for child day care, licensed childcare facilities, preschool and Head Start programs, and public and private primary and secondary schools. The amendments mirror current ACIP recommendations for immunizations for children and adolescents in these age groups and add requirements for pneumococcal vaccine, second dose of varicella vaccine, tetanus, diphtheria, and acellular pertussis (Tdap) vaccine, and meningococcal vaccine. The amendments to this regulation went into effect February 1, 2011, for the school year beginning on or after July 1, 2011.

c. Plan for the Coming Year
In addition to annual VFC/AFIX activities and school surveys in 2011, KIP will finalize protocols for performing adolescent AFIX visits and implement these visits fully.

KIP will also continue education efforts directed at providers, both public and private, schools (public and private), child daycares, other licensed facilities which care for children, preschools, and Head Start programs regarding the regulation changes for immunization requirements for entry into these programs.

Furthermore, the Immunization Registry is expected to complete pilot testing in 2012 and begin implementation statewide. Currently, the Immunization Registry users include all Local Health Department sites, the birthing hospitals in Kentucky, Department of Juvenile Justice facilities, and numerous private providers. Statewide implementation is expected by 2013. Collaboration with KHIE continues as the registry moves toward statewide roll-out.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	23	23	23	23	21
Annual Indicator	25.0	24.7	24.3	21.5	18.9
Numerator	2139	2098	2045	1812	1590
Denominator	85420	85072	84044	84346	84346
Data Source		KY live birth certificate files and U.S. Census Bu	KY live birth certificate files year 2009	KY live birth certificate files year 2010	KY live birth cert file
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	18	18	18	17.5	17.5

Notes - 2011
2011 data is preliminary and numbers could change.

The 2011 Census population estimates are not currently available therefore the denominator reflects 2010 census population estimates

Notes - 2010
2010 data is preliminary and numbers could change.

The 2010 Census population estimates are not currently available therefore the denominator reflects 2009 census population estimates.

Notes - 2009
2009 data is preliminary and numbers could change.

a. Last Year's Accomplishments
Kentucky continues to struggle with high teen birth rates. Traditionally, Kentucky's rates have been at least 10 points higher than the national rates. 2010 Kentucky teen birth rates continue with that trend but the number of teen birth are declining. The nation celebrated another reduction in teen birth rates for 2010 with a rate of 34.3 per 1000 females age 15-19. This is the lowest teen birth rate the nation has seen in decades. Kentucky's teen birth rate for 2010 is 46.7 per 1000 females age 15-19. This is a 16.3% drop from 2008. It is also the lowest teen birth rate Kentucky has seen in decades. Preliminary data for 2011 shows the teen birth rate (per 1,000) for ages 15-19 will also be lower at approximately 42.0. The teen birth rate (per 1,000) for ages 15-17 declined in 2010 with a rate of 21.99. This rate is down from 24.7 in 2008. The teen birth

rates for the Appalachian counties continue to be somewhat higher than the state rate but in 2010 the Appalachian rate dropped 6.25%.

Rates per 1000 KY Data Source: KY Vital StatisticsThe Division of Women's Health directs the teen pregnancy prevention efforts of the Department of Public Health through the Adolescent Health Initiatives Coordinator. They are administering the Title V State Abstinence Education grant and the Personal Responsibility Education Program (PREP) grant. The Adolescent Health Initiatives Coordinator also oversees the utilization of Title V Block Grant funds by LHDs for teen pregnancy prevention. Collaborative efforts are encouraged on the local, regional and state level. Partners for teen pregnancy prevention include, but are not limited to, the Kentucky Teen Pregnancy Coalition, Kentucky Department of Education, Coordinated School Health, Family Resource and Youth Service Center staff at each school, local coalitions, LHD health educators, school teachers, school administration, and community-based organizations.

The Teen Pregnancy Prevention Strategic Plan that was established in the spring of 2010 continues to be the heart of all effort in teen pregnancy prevention in Kentucky. The following four goals are used to develop and implement programs on both a state and local level with all partners across the Commonwealth. These goals are:
1) Age-appropriate personal responsibility and sexuality education to all students,
2) Educate and engage parents and communities,
3) Teen pregnancy prevention promotion through multiple modes of communication,
4) Continue to provide all Kentucky youth with access to reproductive healthcare.

Sexuality and personal responsibility education and parent programs are provided through funding from the Abstinence Education Grant Program, the Personal Responsibility Education Program grant and through MCH funds utilized by the local health departments for these efforts. The 3rd Annual Teen Pregnancy Prevention Summit was held in April this year with 98 attendees. This 2 day meeting provided a variety of education to adults who work with adolescents. It also provided an opportunity for attendees across the state to network and share successes in their location.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Teen Pregnancy Prevention Strategic Plan established in 2010 set the goals to develop and implement programs with all partners statewide.				X
2. Education and engagement by teens, parents, and communities is provided and encouraged for success in teen pregnancy prevention throughout the state.	X	X		X
3. The 3rd Annual Teen Pregnancy Prevention summit was held in April 2012 with 98 attendees.		X	X	X
4. The Kentucky Family Planning Title X Program contributes to programs across the state that target disparate, low income under-insured populations.	X	X	X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The KY Family Planning Title X Program contributes to initiatives targeted to serve disparate populations. Two Hispanic clinics target low income under insured Hispanic clients. Family Participation Workshops encourage parent participation in the decision of minors seeking FP services. The Pike County Male Special Initiative Project services a LHD clinic, a college based clinic, and an in-school program for middle school males who are taught goal setting and self-esteem skills. Title X also helps fund the UK Young Parents Program (YPP) and the Center for Adolescent Pregnancy Prevention (CAPP) in Louisville that provide intensive counseling to teens to prevent pregnancies and repeat teen births and also provide comprehensive adolescent preventative health care services.

The Division of WH Adolescent Health Initiatives section administrates the Abstinence Education Grant Program and the Personal Responsibility Education Program (PREP) grant, utilized to educate students across the Commonwealth about personal responsibility skills, abstinence and contraceptive use (PREP awardees only). Twenty-nine (29) LHD/districts representing 57 counties will receive Title V Abstinence Education funds to use either the Choosing the Best(c) curriculum or the Postponing Sexual Involvement(c) curriculum to educate students in 6th -- 8th grade in 161 middle schools in KY. Twenty-one (21) LHDs representing 47 counties across KY receive funds to use the Reducing the Risk curriculum or TOP Program.

c. Plan for the Coming Year

The Kentucky Department for Public health will continue to make teen pregnancy prevention a priority through collaborative efforts within the department and partners throughout the state. Working with partners such as local health departments, coordinated school health, community-based organizations and interested parties, the Adolescent Health Initiatives Coordinator and the Family Planning section in the Division of Women's Health will continue to utilize the Kentucky Teen Pregnancy Prevention Strategic Plan and federal resources to educate students and parents regarding personal responsibility and sexuality education including abstinence and contraception, promote positive youth development in communities, and continue to provide access to reproductive healthcare to all adolescents in Kentucky.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	30	31	31	25	25
Annual Indicator	29.0	23.9	23.9	23.9	23.9
Numerator	15222	18790	18790	18790	18790
Denominator	52489	78505	78505	78505	78505
Data Source		U.K. denatl sealant program data	UK dental sealant program data	UK dental sealant program data	UK dental sealant program data
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	26	26	26	27	27

Notes - 2011
2011 data is currently not available data for this indicator actually reflects year 2008.

Notes - 2010
2010 data is currently not available data for this indicator actually reflects year 2008.

Notes - 2009
The annual indicator declined and the annual performance objective was set at an increase and cannot be changed for this reporting year. Future objectives have been modified based on the current reporting year.

2009 data is currently not available data for this indicator actually reflects year 2008.

a. Last Year's Accomplishments
The KOHP continues to fund school-based sealant programs through 15 health departments. There has been no consistent process for reporting sealant application through the program. The Kentucky Department for Public Health developed a new Clinic Management System (CMS) with a rollout date of late fall of 2011. The CMS was piloted in two local health departments and is scheduled for a staggered rollout. All the local health departments will be trained on the CMS and the sealant reporting system. This new system will provide more accurate data collection since all health departments will be using the same system.
The reporting system was modeled after the CDC SEALS software with changes relevant to the state reporting requirements and system. In this system, KOHP will be able to link children to providers and get detailed demographic information on these children. This system will also help the KOHP to identify children in need of restorative care. Reporting of referrals made to the local dentist is incorporated in the software and thus follow up on these children can be monitored.

Of specific importance, the KOHP has worked diligently on the Smiling Schools Project as a part of the Governor's Oral Health Initiative to target distressed counties in Eastern Kentucky. The project has two main components: First, a community education component designed to increase individual knowledge of oral disease risk factors, oral disease prevention strategies, and, in general, the societal impact oral disease burden has on communities. Second, a preventive fluoride varnish treatment component which consists of Public Health Nurses applying a protective coating of fluoride varnish to 1st through 5th grade students in target schools to reduce the risk of dental decay.

To date, the Smiling Schools Project has completed each of these activities in target counties. In addition to providing preventive fluoride varnish for some 5,000 schoolchildren, the health education staff developed an education toolkit for dissemination in each community to raise awareness and reinforce good oral health behaviors. These two activities, in concert together, is an effective means to affect a positive health status in these communities by, 1) providing a primary treatment for prevention, and, 2) adding to the knowledge-base of individuals that they may effectively sustain their own family's oral health status.

The Smiling Schools Dental Evaluation Team identified prevalent oral health needs in these

communities, and we can say with confidence, that after analyzing this cohort, more families are seeking dental care. And, this, in addition to early prevention strategies, is the focus and intent of the project. We are confident that steps are being made toward an increased positive oral health status in Eastern Kentucky. Though much progress is being made, the lack of people seeking comprehensive oral healthcare and the prevalent social norm of lacking oral disease awareness mandates our continued efforts in these communities.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. KOHP continues to fund school-based sealant programs through 15 LHDs for local level dental provider partnerships.	X	X	X	
2. The DPH Clinic Management System was piloted in 2 LHDs in 2011 and will continue a staggered roll-out in fall of 2012.			X	X
3. Ongoing support for the Kentucky Children's Oral Health surveillance system, tracking oral disease and sealant use throughout the commonwealth.			X	X
4. Continued oral health education at the local level to families, health providers, including nurses and physicians, and the community.			X	X
5. KIDS Smile Fluoride Varnish Program through LHDs which includes the application of fluoride varnish and good oral health care education to the parents and family.	X	X	X	
6. Continued partnership with UK College of Dentistry and their sealant outreach program, reaching children statewide, and especially in rural, underserved areas.	X	X	X	
7. Ongoing strategic planning for children's oral health care in KY.			X	X
8. Continued collaboration with the UK Center for Rural Health with their growing outreach to underserved populations in rural KY.			X	X
9. The Smiling Schools Project is part of the Governor's Oral Health Initiative targets distressed Eastern KY and increases community knowledge of oral disease prevention strategies.	X	X	X	X
10.				

b. Current Activities

The KOHP continues to fund sealant activities in 15 health departments. LHDs and their community partners continue to move the identified child to the contracted dental office for sealant services.

The accountability and reporting of sealant activities is unpredictable and inconsistent into 2012. The Oral Health Program is currently working with a sister agency, Administrative and Financial Management Division as well as Custom Data Processing in researching, developing and implementing a uniform sealant activity reporting program. Among the goals of this software-based program are to capture appropriate services for this funding stream. This should be finalized in the late fall of 2012. This will allow sensible expansion of the program and its accountability in future years.

KOHP is in its last year of the four-year Targeted MCH Oral Health Service Systems (TOHSS) Grant and received funding of $160,000/year to advance the state oral health program toward sustainability and provide a statewide approach to preventing oral disease. The purpose of

TOHSS is to support the State's capacity to expand preventive and restorative oral health services for Medicaid and State Children's Health Insurance Programs (SCHIP) eligible children and other underserved children and their families. Kentucky's strategies will specifically address increasing the number of children completing restorative treatment needs identified through children seen through the Kentucky Sealant Program.

c. Plan for the Coming Year

Oral health coalitions, funded through ARC grants, will soon be eligible for portable dental equipment that can be used in school sites. Three awards will be given, and sealant applications in those communities will be monitored. It is anticipated that the portable equipment will be used widely in school systems.

Recent changes in the dental practice law will catalyze the development of a sealant program that will be school-based more than contract-dentist based, which is a recognized 'Best Practice' by the Association of State and Territorial Dental Directors. It will use the limited funding through the most effective sealant delivery system in public health: its school-based services through a newly established level of hygienist licensure: the Public Health Registered Hygienist. Protocols are being developed and will include applying dental sealants.

The Kentucky Oral Health Program will continue its long standing contractual relationship with the University of Kentucky College of Dentistry to underwrite their efforts in outreach services to Kentucky's underserved pediatric population. The fund allows the University to expand its services geographically in the upcoming year. While continuing their fixed clinic and mobile dental outreach in southeastern Kentucky as well as their mobile outreach and fixed clinic in Madisonville, they are implementing a significant expansion of their program in the northeastern part of the state. Their mobile dental services for children throughout the state will continue in areas they identify as underserved with emphasis on prevention (including sealants).

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	4.5	3	2.5	2.5	2
Annual Indicator	2.5	2.9	3.0	2.1	1.2
Numerator	21	24	25	18	10
Denominator	828157	833890	841552	849409	849409
Data Source		KY vital stats death certificate files & U.S. cens	KY vital stats death cert files	KY vital stats death cert files	KY vital stats death cert files
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year,					

and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	1.1	1.1	1.1	1	1

Notes - 2011
2011 data is preliminary and numbers could change. 2011 census population estimates are not currently available therefore, 2010 population estimates were used for the denominator.

Notes - 2010
2010 data is preliminary and numbers could change.

Notes - 2009
2009 data is preliminary and numbers could change.

a. Last Year's Accomplishments
In 2011, education and support for child passenger safety was provided to more than 5000 people. Kentucky's rates have shown a steady decrease for the past 3 years, with the 2011 rate being the overall lowest in the past 7 years. Examples include HANDS (home visiting program) staff, Promatores (Hispanic lay health advisors), Migrant Education and Commission for Children with Special health Care Needs staff, Head Start staff, child care health consultants and child care center directors and staff, school nurses, grandparents raising grandchildren, and foster parents. Thanks to state-sponsored training the year before, every Ky State Police post began the year with a nationally certified CPS technician available to assist the public and train fellow officers. The State Booster Seat Coalition observed booster violations written by each county, to see if the DVD sent to all law enforcement agencies had been of any help in raising awareness of the Booster bill/improving recognition of booster seats. Legislative upgrade to the new Booster Bill was considered, which would revise Kentucky's current requirements for children in boosters to meet National Highway Traffic Safety Administration (NHTSA) recommendations, but the final decision was to first implement the current bill as a faster way to improve MVC death rates. Kentucky's current bill requires that booster seats be used until a child is at a height between 40 and 57 inches, per NHTSA recommendations.

Child care booster seat project- MCH and the MCH/KIPRC pediatric injury staff were asked to work with Child Care on a Federal Stimulus Funds project to distribute booster seats to child care centers that transport low income children. Eligible centers and most appropriate types of booster seats for vans were determined and seats ordered. A 2-hour educational component which would qualify for child care provider education credits was envisioned and then created by KIPRC in collaboration with other state child passenger safety instructors. This class was provided at the first regional child care van seat distribution event. It was well-received. The hope was that through education of child care providers (including but not limited to the van drivers, as the class 92 attracted an additional 2/3 of providers) that motor vehicle safety would be improved both in day care transport and through modeling by these providers to parents of children in their care.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**

	DHC	ES	PBS	IB
1. Education and support for child passenger safety was provided to more than 5000 people in 2011 and continue at all 120 LHDs and district offices.		X	X	
2. Every Kentucky State Police post has nationally certified CPS technicians available to assist the public and to train officers.		X	X	X
3. Intensive assistance in childhoood injury prevention is being offered to counties through affiliations with Safe Kids.	X	X	X	X
4. Booster seats are now available for children in foster care provided to Medical Home Clinic.		X	X	
5. Families with special health care needs children have access to specially certified child passenger safety techs from Riley Children's Hospital in three state sites.		X	X	
6. Child Care Booster Seat education and booster seat distribution program was organized and seats provided in eastern, northern and mid-southern regions of the state.		X	X	
7. Collaboration with CDC grants including the KY Violent Death Reporting Systems grant administered by DPH including multiple partners and collaborations.				X
8. Collaboration with the KY Injury Prevention Research Center at UK.				X
9. Ongoing strategic planning for children's safety and injury prevention in KY.				X
10. Annual publication of the Child Fatality Review Report.				X

b. Current Activities

Statewide efforts continue to assist families in properly restraining infants and toddlers in car seats and older children in booster seats. The injury prevention staff at MCH working with their contract Pediatric and Adolescent Injury Prevention Program at the KY Injury Prevention and Research Center (KIPRC) emphasize support and education for agencies, groups, and programs that reach individual families. Support and educational materials are provided to 120 LHDs and their district offices.

Children in foster care are eligible for booster seats provided to the Medical Home Clinic through a Junior League small grant. Families of children with special health care needs have access to certified child passenger safety techs with extra training from Riley Children's Hospital, located in three state sites. New Safe Kids programs are being launched to provide injury prevention or child passenger safety activity. Through this year KIPRC on behalf of MCH has participated in the Children's Safety Network Rural Community of Practice (CSN Rural COP), and is emphasizing rural motor vehicle crash prevention and the sustenance of a rural nationally certified child passenger safety workforce.

c. Plan for the Coming Year

Work on sustaining cadre of nationally certified Child Passenger Safety (CPS) techs in a rural state (part of CSN Rural COP as above), work on maintaining CPS programs in local county health departments in face of dwindling resources, support Safe Kids Chapters and assist them in 93 maintaining skills through statewide planning process for updates and technical education, support growth of senior CPS person in each local region to increase rural local independent CPS capacity, support big new Safe Kids chapter in northwestern population center and Safe Kids chapter that serves both local county and extensive populations of military families on Fort Campbell. Initiate and maintain dissemination efforts for new AAP/Safe Kids/NHTSA recommendations for rearfacing until age 2 and booster seats until reach adult height, with new emphasis to improve safety for thin children as well as overweight ones. Complete revision of booster seat training module for child care to reflect these new national CPS recommendations.

Complete training and booster seat distribution for remaining northern and southern border day care centers and far western counties. Implement new Safe Kids child passenger safety module for tweens. Work to translate CFR cases into new education about (underage) teen driving on farms and rural land, for cars, trucks and UTVs.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	26	28	29	29	30
Annual Indicator	23.2	28.9	28.9	29.6	29.6
Numerator	3416				
Denominator	14725				
Data Source		CDC National Immunization survey state specific da	CDC National Immunization survey state specific da	CDC National Immunization survey state specific da	CDC National Immunization survey state specific da
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	30	31	31	32	32

Notes - 2011
Numerator and denominator information is not available for this indicator as the data source is now the CDC National Immunization Survey.

Notes - 2010
Numerator and denominator information is not available for this indicator as the data source is now the CDC National Immunization Survey.

Notes - 2009

2009 data is not currently available data shown reflects year 2008.

Numerator and denominator information is not available for this indicator as the data source is now the CDC National Immunization Survey.

The annual indicator declined and the annual performance objective was set at an increase and cannot be changed for this reporting year. Future objectives have been modified based on the current reporting year.

a. Last Year's Accomplishments

During 2011, breastfeeding initiation and duration rates were maintained through training, education, promotion, and support. The Second Annual Breastfeeding Summit was held in April 2011 in Louisville Kentucky in conjunction with the Kentucky Dietetic Association and 120 public and private partners were in attendance. This meeting unveiled the statewide breastfeeding coalition and the rollout of the "Strategic Plan to Increase Breastfeeding Rates in Kentucky." Committees were formed for each topic area of the Breastfeeding Strategic Plan. Each committee is completing assessments to determine current breastfeeding services and needs. Assessments of hospitals, physician offices, support services, higher education facilities and health departments were underway. As part of the strategies for the Breastfeeding Strategic Plan the Kentucky WIC Program partnered with the University of Louisville Hospital to provide training on Kangaroo Care, skin-to-skin contact between mother and babies immediately after birth, to all birthing hospitals in Kentucky. 100% of birthing hospitals were trained on Kangaroo Care and have set implementation dates for skin-to-skin care in their facilities. A Certified Lactation Specialist (CLS) Course was offered in Kentucky on September 26-30, 2011, to help increase the number of International Board Certified Lactation Consultants (IBCLCs). Six (6) breastfeeding coalitions including the statewide coalition continue to be active and provided continuing education, support and leadership for health professionals. World Breastfeeding Week was held in August and included activities across the state for mothers and health professionals, as well as press releases. The Rock and Relax Room was continued at the State Fair in Louisville, KY. Funding was continued for the eleven Regional Breastfeeding Coordinators. Training and technical assistance was provided to the Peer Counselor sites. The total number of sites increased from 17 to 20. Education materials continue to be developed and translated into Spanish. The breastfeeding bill, KRS 211.755 continues to be promoted in an effort to increase awareness about breastfeeding protection in public places. KRS 29A.100 allows breastfeeding mothers to be excused from jury duty. Collaboration continues with the obesity team and Partnership for FIT Kentucky, who include breastfeeding in the workplace as one of their strategies in the plan published in 2009, Shaping Kentucky's Future Policies to Reduce Obesity. Business Case for Breastfeeding trainings and outreach have been provided to local businesses across the state. Collaboration continues with the University of Kentucky, University of Louisville and other public and private partners. The Baby Friendly Hospital Initiative continues to be promoted. Staff continues to work on new ideas to promote breastfeeding in Kentucky.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. SPH staff & regional coordinators provide training, education, promotion, and support to breastfeeding women which maintained the increase in breastfeeding initiation & duration rates for 2011.	X	X	X	X
2. The 2nd Annual Breastfeeding summit held in April 2011 rolled out the Strategic Plan to Increase Breastfeeding Rates in Kentucky. The summit included the KY Dietetic Assoc. and 120 public and private partners.				X
3. 100% of birthing hospitals in KY trained on Kangaroo Care	X	X	X	X

and have set implementation dates for skin-to-skin care in thier facilities.				
4. A Certified Lactation Specialist Course was offered in KY in 2011 to help increase the number of International Board Certified Lactation Consultants.		X		X
5. Six breastfeeding coalitions continue to be active and provide continuing education, support and leadership for health professionals.		X		X
6. The total number of Peer Counselor sites has increased from 17 to 20 statewide.	X	X	X	X
7. Collaboration continues with the state obesity team and Partnership for a Fit Kentucky.				X
8.				
9.				
10.				

b. Current Activities

The Third Annual Breastfeeding Summit was held in March 2012 and was attended by 150 public and private partners. The Summit featured the update of the Breastfeeding Strategic Plan. Continuing assessment and analysis of Breastfeeding Strategic Plan areas are being performed by the State Plan Committees. Section staff and Regional Breastfeeding Coordinators are working to support all birthing hospitals in Kentucky as they go live on or before July 2012 with Kangaroo Care. WIC participants receive hospital and single user breast pumps to support duration. The Baby Friendly Hospital Initiative is being supported across the state. New education modules are available to local agency staff on breastfeeding promotion, breastfeeding education and three-step counseling. A Certified Lactation Counselor (CLC) course will be offered to increase the number of International Board Certified Lactation Consultants (IBCLCs) in KY. KY continues to promote the Business Case for Breastfeeding in collaboration with Partnership for FIT Kentucky and the obesity team, who included breastfeeding in the workplace as one of their strategies in the plan published in 2009, Shaping Kentucky's Future Policies to Reduce Obesity. The Breastfeeding Peer Counselor Program is continuing in 20 agencies and will be increasing. The statewide breastfeeding coalition is being promoted and supported.

c. Plan for the Coming Year

Efforts will continue to work to increase breastfeeding initiation and duration rates through continued education, promotion and support. Funding will be maintained and continued for the eleven Regional Breastfeeding Coordinators. Intensive breastfeeding training will be offered in the state to increase the number of International Board Certified Lactation Consultants (IBCLCs) and Certified Lactation Counselors (CLC)/Certified Lactation Specialists (CLS). Staff will continue to provide breastfeeding and nutrition continuing education programs. Efforts will be focused on increasing the number of hospitals trained on breastfeeding promotion and support and the number of hospitals that implement Kangaroo Care. Breast pumps (hospital and single user) will continue to be provided to WIC mothers. The goals of the Baby Friendly Hospital Initiative will continue to be supported and promoted in the state. Online education modules on breastfeeding and nutrition will continue to be developed for local health department staff training. The Breastfeeding Worksite Toolkit will continue be promoted throughout the state along with Health Care Reform. Collaboration continues with the Obesity Team and Partnership for FIT Kentucky. The staff will continue to promote and support breastfeeding and nutrition through participation in health fairs and conferences with displays and education materials. The Breastfeeding Peer Counselor Program will be continued in 20 sites and will increase to other sites. The Strategic Breastfeeding Plan strategies will continue to be implemented across the state. The six strategies include: Maternity Care and Hospital Practice, Support for Breastfeeding in the Workplace, Peer Support, Educating Mothers and Families, Healthcare Professional Support and Media and Social Marketing. Collaboration with Partnership for a FIT KY, University of Kentucky, and University of

Louisville and other public and private partners will be continued. Efforts will continue to focus on breastfeeding legislation. Staff will continue to revise and develop breastfeeding and nutrition education materials for local agencies. Participation in health fairs and the Rock and Relax Room at the State Fair will continue with an effort to promote and support breastfeeding and nutrition. Kentucky will participate in World Breastfeeding Week during August 2012.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	99	99	99	99	99
Annual Indicator	99.0	97.8	99.9	96.6	98.1
Numerator	57619	55635	55250	50713	51155
Denominator	58184	56886	55290	52498	52132
Data Source		EHDI Program (CY 08)	As of 5/20/10	EHDI program/Vital Statistics (6/10/11)	EHDI program/Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	99	99	99	99	99

a. Last Year's Accomplishments
Collaboration began with the Kentucky Commission for Deaf and Hard of Hearing, which is providing a packet of information and resources for the EHDI program to send to all families of newborns diagnosed with permanent hearing loss. Similarly, collaboration began with the Hands and Voices "Guide by Your Side" program, which provides parent mentors to newly diagnosed families.

CCSHCN has expanded the collaborations with other partners, by providing a feasibility study for data exchange with First Steps (Early Intervention), HANDS (Kentucky's Home Visiting Program) and Hands and Voices, to improve outcomes for children identified with hearing loss and to work with families to find resources and overcome barriers. Specifically, continued collaboration via MOA with Part C (to address sharing of individual identifiable information regarding enrollment in Early Intervention services) is resulting in an increase in the numbers of infants/toddlers referred for and receiving comprehensive audiology evaluations and related services at CCSHCN offices throughout the state.

CCSHCN is also working with the birthing hospitals in increasing their compliance with data reporting requirements for newborn hearing screens. Bimonthly emails are sent to hospitals that are out of compliance with timeframes for reporting so that the hospitals can engage staff in process improvement.

Purchases were made to replace aging audiometric equipment in all CCSHCN district offices and thereby increase access for families to appropriate diagnostic audiology services following "referral" from the newborn hearing screening.

The implementation of a statewide Cochlear Implant (CI) Program at CCSHCN has been an exciting development toward providing a team approach to support families and children who choose implantation as an access to communication/language. Bowling Green and Louisville CCSHCN offices provide CI activation and programming (MAPping) and approximately 20 children are enrolled in the CCSHCN CI program. All CCSHCN regional offices provide hearing aid related services in addition to initial CI candidacy evaluations. In light of the success of the CCSHCN CI program, plans have been made to expand CI MAPping services to Eastern Kentucky (CCSHCN Hazard).

Contact was made with the Public Health Departments and state certified Midwives to offer information regarding the screening and re-screening of newborns.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The EHDI program provides onsite support to all KY birthing hospitals.	X			
2. KY birthing hospitals screen all newborn hearing prior to hospital discharge.	X		X	
3. Results from hospital screenings are submitted electronically to the EHDI program. Information is maintained in the CCSHCN electronic data system.				X
4. Information is mailed to families of children who have a newborn hearing screen report indicating a risk for hearing loss. The information provides information about the risk and diagnostic audiological follow-up resources.		X	X	
5. The EHDI program provides follow-up to families who are not documented as having received diagnostic audiological testing.	X	X	X	X
6. The EHDI program employs a coordinator to provide oversight to the loss to follow-up initiative.	X	X	X	X
7. The EHDI program manages two grants from HRSA/MCHB and the CDC to be used in reducing the loss to follow-up rate.			X	X
8. The EHDI program partners with the Office of Technology to coordinate an electronic system of information with hospitals and audiologists.			X	X
9. The EHDI program provides outreach and training to stakeholders.			X	X
10. Information about the EHDI program is available on the CCSHCN website (in English and Spanish).	X		X	X

b. Current Activities

CCSHCN is working towards expansion of KY CHILD to allow for additional data to be transferred to CUP. A pilot program for direct electronic entry from hospital screening equipment to the KY CHILD hearing screen report is in the planning stages. Reduction of loss to follow up at diagnosis

and early intervention is expected with increased access of electronic reporting.

Subsequent to participation in the National Initiatives for Children's Health Care Quality (NICHQ) Learning Collaborative, PDSA initiatives were implemented. As a result, an improvement in scheduling of audiology follow up appointments prior to newborn hospital discharge is noted. In addition, improved communication with specific physician practices regarding warranted follow up has been experienced statewide.

Collaborations and possible written agreements with surrounding states to facilitate the exchange of information began in February 2012.

Funding requests for purchase of hearing aid programming equipment, diagnostic testing equipment and for expansion of the CI Program to the CCSHCN Hazard, KY regional office have been submitted. Provision of requested equipment will enable staff audiologists to adhere to preferred practice patterns for the profession.

Letter disseminated by the EHDI program to parents of infants who referred or who presented with risk factors has been revised (as a result of parent input) and its use will be implemented this year.

c. Plan for the Coming Year
Hospital scorecards are being piloted with relevant data and comparisons to state and national averages.

Evaluation and use of competency tools for Approved Audiology Providers who are non-CCSHCN audiologists will be piloted.

Annual site visits to all 52 birthing hospitals by CCSHCN Audiology staff will be continued.

Improved documentation of enrollment in Early Intervention services (by age 6 months) for infants diagnosed with hearing loss by:

1. Partnering with Point of Entry consultants for Part C (including provision of Early Childhood Hearing Outreach (ECHO) training) by CCSHCN Audiology staff; and
2. Proactive collaboration between Family to Family Health Information Center (F2FHIC) parent consultants and EHDI/Audiology staff (using the CCSHCN database task function to monitor)

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	8.5	9	8	9	8
Annual Indicator	8	10	10	8.2	6.8
Numerator					
Denominator					
Data Source		U.S. Census Bureau Current Population	U.S. Census Bureau Current population	U.S. Census Bureau Current Population	U.S. Census Bureau Current Population

		Survey for 2	survey for 2	survey for 2	Survey for 2
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	6.5	6.5	6	6	6

Notes - 2011
2011 data not available yet, so 2010 data is used for preliminary reporting. Data for this indicator was obtained from Census Current Population Survey, Annual Social and Economic Supplement. Numerator and denominator were not available.

Notes - 2010
2010 data not available yet, so 2009 data is used for preliminary reporting. Data for this indicator was obtained from Census Current Population Survey, Annual Social and Economic Supplement. Numerator and denominator were not available.

Notes - 2009
Data for this indicator was obtained from Census Current Population Survey, Annual Social and Economic Supplement. Numerator and denominator were not available.

a. Last Year's Accomplishments
In an effort to encourage preventive health exams, as well as insurance coverage for children, MCH, through a contract with the Department for Medicaid Services, conducts EPSDT and KCHIP Outreach. Statewide local health departments work with community providers, schools and other community agencies to promote preventive care and Medicaid and KCHIP enrollment. Health department EPSDT and KCHIP outreach activities include distribution of information and materials, face to face, phone and written contacts with families of eligible children. LHDs also provide KCHIP applications and assistance to complete the applications in order to increase Medicaid and KCHIP enrollment. More than 360 LHD administrative, support and nursing staff provide outreach services. These activities are part of the Governor's initiative to increase the enrollment of children in Medicaid and KCHIP. By June, 2009 LHDs, community and government providers and agencies enrolled more than 35,000 children in Medicaid and KCHIP.

Since April, 2010 an additional 13,544 children have been enrolled in Medicaid and KCHIP. Health departments reported participating in over 49,000 EPSDT and KCHIP Outreach activities in SFY 2012. KCHIP application Training is now provided on the Kentucky Department of Medical Services website for community providers, schools and agencies. The percentage of children without health care coverage went from 10% in 2009 to 6.8% in 2011.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**

	DHC	ES	PBS	IB
1. Over 45,000 children were enrolled in Medicaid and KCHIP since the beginning of the Governor's KCHIP enrollment plan began on November 1, 2008.	X	X	X	
2. Collaboration continues between DPH and the Department for Medicaid Services to access needed data for MCH programs.				X
3. Collaboration continues with EPSDT Outreach through the LHDs.		X	X	X
4. Collaboration continues with EPSDT and LHD Well Child programs.		X	X	X
5. More than 360 LHD administrative, support and nursing staff provide KCHIP outreach services.	X	X	X	
6. The percentage of children without health care coverage decreased from 10% in 2009 to 6.8% in 2011.		X	X	
7. DPH is working with computer services partners & resources to enhance EPSDT Outreach activities to include KCHIP eligible children to identify gaps in services and coverage for this population.				X
8.				
9.				
10.				

b. Current Activities

Statewide efforts to implement the Governor's KCHIP enrollment plan have exceeded the goal to enroll more than 35,000 children by June 2010. As of May 2012, over 45,000 children were enrolled in Medicaid and KCHIP since the beginning of the initiative on November 1, 2008, local health departments continue to provide KCHIP applications, offer or provide assistance with completing, submitting and tracking the status of the applications efforts to families of uninsured or underinsured children in Kentucky. Currently Families of eligible or uninsured or underinsured children will be provided with information about KCHIP and EPSDT through community schools, providers and agencies.

Since July 2011 there have been 460,067 participants in statewide EPSDT Outreach activities provided by LHD staff. In these activities 7,010 participants were provided or assisted with KCHIP applications.

c. Plan for the Coming Year

Plans for the coming year are to increase the percentage of children enrolled in Medicaid or KCHIP. During CY 2012, the Department for Public Health will work with computer services partners and resources to enhance the following EPSDT Outreach activities with follow-up to include KCHIP eligible children: identifying children in need of preventive health services and coverage through outreach in local health department clinics and partnering with statewide and community providers and agencies to make families of eligible children aware of the need for preventive health services. DMS and DPH will work with local health department outreach programs to engage providers in outreach and promote EPSDT services to families of children who are uninsured, underinsured or eligible for KCHIP.

The Department for Public Health will pursue further improvement of EPSDT Outreach in state fiscal year 2013 by evaluating budget and planning goals and objectives, monitoring statewide and county outreach activity and expenditures goals and objectives quarterly and as needed, providing local health departments with training and technical assistance as well feedback about program performance, and collaborating with the Department for Medicaid services and health departments in 120 counties to increase public and provider awareness of EPSDT services. The

Department of Medicaid Services Membership Line will take over responsibility for the KCHIP Hotline for the SFY 13.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	34	16	31	30	30
Annual Indicator	32.0	32.3	31.3	31.6	31.6
Numerator	18277	20294	21450	23759	23759
Denominator	57117	62832	68450	75189	75189
Data Source		Pediatric Nutrition Surveillance Survey for KY	Pediatric Nutrition Surveillance Reporting System	Pediatric Nutrition Surveillance System state spec	Pediatric Nutrition Surveillance system state spec
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	29	29	29	28	28

Notes - 2011
2011 PedNSS data is not currently available therefor, 2010 data was used.

Notes - 2010
For data year 2006, children between 2 and 5 who were obese were not included in the numerator only those at risk for being overweight were reported; therefore, the 2006 indicator appears lower than other years. For years 2007 and forward those children receiving WIC between the ages 2 and 5 at risk of overweight or obese were reported in the numerator.

Notes - 2009
For data year 2006, children between 2 and 5 who were obese were not included in the numerator only those at risk for being overweight were reported; therefore, the 2006 indicator appears lower than other years. For years 2007 and forward those children receiving WIC between the ages 2 and 5 at risk of overweight or obese were reported in the numerator.

a. Last Year's Accomplishments

During 2011, funding was provided for a network of Registered Dietitians/Certified Nutritionists to provide Medical Nutrition Therapy (MNT) in 110 of 120 counties. Funding was also provided for community and school nutrition activities in all 58 agencies. The staff provided wellness and nutrition activities at various health fairs and conferences. State and local staff provided nutrition information at the Kentucky State Fair and answered questions for attendees. Nutrition materials were developed or revised for local health departments to use with clients. The staff completed the nutrition monitoring for quality assurance in 20% of agencies. Technical assistance for Value Enhanced Nutrition Assessment (VENA) has been implemented statewide and continues to be provided to local agencies which was implemented statewide. Staff is a liaison to the following committees/coalitions: Kentucky Action for Healthy Kids, Partnership for a Fit Kentucky, Kentucky Diabetes Network, Folic Acid/Prematurity Partnership, School Health Coalition, AHEC Health Careers Outreach and Kentucky Food Security Partnership.

Kentucky's WIC Program is available in all 120 counties. The WIC Program provides counseling to all children and women concerning healthy foods and the importance of regular physical activity. The average caseload for WIC is approximately 136,000 participants.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Physical Activities promoted through LHDs.	X		X	X
2. Nutritional counseling to families available through LHDs.	X		X	X
3. Collaboration between LHDs and schools to promote physical activity and nutrition.		X	X	X
4. Wellness and nutrition activities provided for KY employees and nutrition information provided at KY State Fair.	X	X	X	
5. Training and technical assistance provided for participation in WIC Farmer's Market Nutrition Program	X	X	X	X
6. Well Child and Adolescent Prevention Health and Nutrition services training provided for LHD staff.				X
7. Continued collaboration and strategic planning with multiple partners.			X	X
8. Automated BMI and Growth Charts.	X	X	X	
9. WIC Program in all 120 counties, statewide, provides counseling to all children and women on healthy foods and the importance of regular physical activity.	X	X	X	X
10. WIC EBT rollout continues statewide.	X	X	X	X

b. Current Activities

The redemption of the fresh fruits/vegetables in the WIC food package continues to increase with of the use of WIC EBT (Electronic Benefits Transfer). Funding continues for the local health department dietitian/nutritionist network. Nutrition and breastfeeding materials continue to be revised and updated. The most noteworthy revisions are those of the WIC FIT Kit and the Breastfeeding Resource Guide. Quality assurance monitoring and technical assistance continues. Liaison relationships continue with Partnership for a Fit KY, Folic Acid and Prematurity Partnership, KY Diabetes Network, Breastfeeding Coalitions, the statewide Breastfeeding Coalition (Lactation Improvement Network of Kentucky) Coordinated School Health Coalition, AHEC and the KY Food Security Partnership. Work continues with KCTCS on the online education modules which will be pilot tested for use to train local health department staff. Training and technical assistance for local agencies will continue to be a focus. A Breastfeeding Newsletter and Nutrition Newsletter are developed and disseminated on a quarterly basis. 5-2-1-0, Healthy Numbers for Kentucky Families has been adopted for use by the WIC Program. WIC

assisted in the statewide training for this initiative. WIC partners with the statewide breastfeeding coalition in the Strategic Plan for Improving Breastfeeding Rates in Kentucky.

c. Plan for the Coming Year

For the future, the staff will continue to work on the web-based system for WIC and add a nutrition education module. The WIC Farmers' Market Nutrition Program will be continued as USDA funding is continued and staff will provide training, technical assistance and monitoring. The quality assurance monitoring will continue to be provided by staff and training and technical assistance will occur as needed. Funding will continue for the dietitian/nutritionist network to provide Medical Nutrition Therapy (MNT), as appropriate. Staff will continue to offer nutrition leadership and provide opportunities as nutrition preceptors. Breastfeeding and nutrition materials will be developed or revised as needed. The following programs will continue to have liaisons: Partnership for a Fit Kentucky, Folic Acid and Prematurity Partnership, KY Diabetes Network, Breastfeeding Coalitions, Coordinated School Health Coalition, AHEC, March of Dimes and the KY Food Security Partnership. The staff will continue to provide a nutrition focus at health fairs and conferences. A Breastfeeding Newsletter and Nutrition Newsletter will be continued on a quarterly basis. Work on the Strategic Plan for Improving Breastfeeding Rates in KY will continue. Nutrition information and displays will continue to be provided at the State Fair.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	22	21	20	20	19
Annual Indicator	22.5	22.8	21.4	20.3	20.4
Numerator	13084	12891	11888	10924	10711
Denominator	58164	56596	55628	53756	52486
Data Source		KY Vital Statistics files, live birth certificate	KY Vital Statistics files live birth cert files	KY Vital Statistics live birth cert files year 201	KY Vital statistics live birth cert files year 201
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	19	18	18	18	17

Notes - 2011
2011 data is preliminary and numbers could change.

Notes - 2010
2009 data is preliminary and numbers could change.

The annual indicator increased and the annual performance objective was set at an decrease and cannot be changed for this reporting year. Future objectives have been modified based on the current reporting year.

Notes - 2009
2009 data is preliminary and numbers could change.

The annual indicator increased and the annual performance objective was set at an decrease and cannot be changed for this reporting year. Future objectives have been modified based on the current reporting year.

a. Last Year's Accomplishments
Kentucky's current smoking among adults is 24.9 (2010 BRFSS). Kentucky ranks second highest in the U.S. behind West Virginia. 2009 preliminary data shows that smoking among pregnant women is 24.3%. According to the 2011 Youth Risk Behavior Survey, middle school current smoking is 9% and high school current smoking is 24.1%.

The GIFTS Program was expanded to include two metropolitan areas and two rural counties. The two metro areas integrated the GIFTS protocol into existing programs such as HANDS and Healthy Start; the two rural counties integrated the protocol in all prenatal clinic visits.

Local health departments assess every pregnant woman on their use of alcohol, tobacco, secondhand smoke exposure, and other drug at each health department visit and provide education and referrals. Local health departments offer group cessation and/or coordinate those services in their communities. Kentuckians who want to stop using tobacco within the next 30 days or are concerned about a family member or friend's tobacco use can call 1-800-Quit-Now (1-800-784-8669). If contemplating quitting log on to www.QuitNowKentucky.org for resources to help you get ready to quit. All tobacco cessation services are free and are available in English and Spanish.

A statewide comprehensive smokefree law bill was introduced at the beginning of the 2012 legislative session. The bill was assigned to Health & Welfare and passed favorably however no other actions were taken during the session.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Nineteen municipalities in KY are covered by comprehensive ordinances or regulations requiring 100% smoke-free workplaces; 33 municipalities have a smokefree ordinance that prohibits smoking in the workplace.				X
2. LHDs assess all women of child-bearing age on their use of alcohol, tobacco, secondhand smoke exposure, and other drugs at each visit, and provide education and referrals	X	X	X	
3. LHDs offer group cessation and /or coordinate those services in their communities.	X	X	X	
4. The Tobacco Prevention and Control Program provides a state quitline to all KY residents free of charge, and tobacco	X	X	X	

cessation services are available in English and Spanish.				
5. The Tobacco Program collaborates with Coordinated School Health, the Division of Substance Abuse and Alcoholic Beverage Control and school districts to focus on youth prevention.				X
6. As a result of these collaborations, twenty-three school districts, covering 124 schools statewide, have implemented comprehensive 100% tobacco free policies.		X	X	X
7. The Tobacco Program and partners will continue to work toward a comprehensive smoke-free state law in 2013.				X
8.				
9.				
10.				

b. Current Activities
Nineteen municipalities in KY, or approximately 34 percent of Kentucky's popoulation, are covered by comprehensive ordinances or regulations requiring 100% smoke-free workplaces. Overall, there are 33 municipalities have a smokefree ordinance (or regulation) that prohibits smoking in workplaces and covers over 45% of the population.

The Tobacco Program hired a staff person (November 2011) to focus on youth prevention. Current projects are: 1) a partnership with the Coordinated School Health Program, 20 Students Taking Charge mini-grants were awarded to school groups to focus specifically on reducing tobacco use in schools through policy development; 2) applied for a FDA grant to focus on reducing youth initiation to tobacco use through parent involvement and mass media; 3) reducing illegal sales to minors in collaboration with the Division of Substance Abuse and Alcoholic Beverage Control by offering free tobacco retailer training on FDA rules and regulations on the sale of tobacco products; 4) presented plaques to 23 school districts (covering124 schools) for their implementation of comprehensive 100% tobacco free policies.

The GIFTS Program ended June 30, 2012 as a result of decreased funding.

c. Plan for the Coming Year
The Tobacco Program and partners will continue to work toward a comprehensive smoke-free state law in 2013; launch tobacco retailer training statewide; continue Students Taking Charge; continue to promote 100% tobacco free schools; expand quit services by adding text messaging and electronic fax referral capability.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	7	8	8	7.5	5
Annual Indicator	10.6	9.2	8.6	5.1	6.7
Numerator	30	26	25	15	20
Denominator	282187	282620	289770	296795	296795
Data Source		KY vital	KY vital	KY vital stats	KY vital stats

		stats death cert files & U.S. census bure	stats death cert files	death cert files year 2010	death cert files year 2011
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	6.5	6.5	6	6	5.5

Notes - 2011
2011 data is preliminary and numbers could change. 2011 population estimates are currently not available therefore, 2010 population estimates were used for the denominator.

Notes - 2010
2010 data is preliminary and numbers could change.

Notes - 2009
2009 data is preliminary and numbers could change.

a. Last Year's Accomplishments
The Child Fatality Review (CFR) program collaborates with the Kentucky Division of Behavioral Health (DBH) encouraging communities to be proactive in awareness, education and intervention for suicide prevention. Suicide is the second leading cause of death for Kentucky's youth and young adults. In 2009, Kentucky ranked 15th highest among states for youth suicide deaths, with 79 deaths between ages 10 to 24.

In spring 2010, Kentucky passed two new laws mandating suicide prevention training for school staff and suicide prevention information for students. DBH continues to provide training and programming to assist schools in meeting these mandates, to include use of a video produced by state suicide prevention personnel: "School-based Suicide Prevention: A Matter of Life and Death".

The Division of Behavioral Health is also focusing on collaborative efforts with the National Action Alliance for Suicide Prevention, particularly the efforts of the Clinical Care and Intervention Task Force. These efforts reflect a paradigm shift for healthcare organizations and providers, and are based on successful models of suicide prevention and cost reduction through systems changes in Core Values, Systems Management, and Evidence-Based Clinical Care Practice.

The Child Fatality Review Program also collaborates with the Kentucky Violent Death Reporting System (KVDRS) to identify issues and at-risk populations, evaluates policies, and identifies topics for peer-reviewed publications and reports. KVDRS provides summaries of statistics, identification of new issues, answers to questions and concerns, and lessons learned.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Child Fatality Review Program (CFR) collaborates with the Kentucky Division of Behavioral Health (DBH) encouraging communities to be proactive in awareness, education and intervention for suicide prevention.		X		X
2. DBH provides training and programming to assist schools in meeting mandates for staff training and educating students in suicide prevention.	X	X	X	
3. CFR collaborates with the Kentucky Violent Death Reporting System to identify issues and at-risk populations, evaluate policy, and identify topics for peer-reviewed publications and reports.				X
4. CFR program and State Suicide Prevention programs are represented at each other's meetings to assist in, and maintain awareness of , issues of both programs related to suicide awareness and prevention.				X
5. In 2010 Kentucky passed two new laws mandating suicide prevention training for school staff and suicide prevention information for students.	X	X	X	X
6. Kentucky DBH received a three-year federal grant from SAMHSA for youth suicide prevention entitled Suicide Prevention Efforts fo Adolescents in Kentucky (SPEAK).			X	X
7. KVDRS provides evaluations and strategies for data collection improvement with other states, public health and injury professionals in the form of descriptive statistics, special reports, and collaborative efforts such as grant submissions.				X
8. Kentucky CFR collaborates with the University of Kentucky Injury Prevention Program on a continuing basis.				X
9.				
10.				

b. Current Activities

In August of 2011, the Kentucky Division of Behavioral Health (DBH) received a three year federal Garrett Lee Smith (GLS) grant from the Substance Abuse and Mental Health Services Administration for youth suicide prevention. This grant is entitled Suicide Prevention Efforts for Adolescents in Kentucky (SPEAK).

SPEAK provided suicide prevention gatekeeper training for 10,000 adults, clinical level suicide prevention training for 8,000 clinicians and the evidence-based program Signs of Suicide for 10,000 youth within their school environment.

The substance abuse prevention branch of DBH recently assisted the suicide prevention efforts through funding for evidence-based suicide prevention kits for schools, providing opportunities for suicide prevention training among RPCs (regional prevention centers for substance abuse) and KPN (Kentucky Prevention Network), as well as encouraging RPC staff to get involved in suicide prevention training for school staff.

KVDRS provides evaluations and strategies for data collection improvement with other states, public health and injury professionals KVDRS also promotes child fatality review at all coroner basic training, in-service training and to individual counties.

c. Plan for the Coming Year
The CFR Program will continue to collaborate with DBH and its State Suicide Prevention Program. The State Suicide Prevention coordinator attends state CFR meetings. The state CFR coordinator also attends and will be more involved in the planning committee of the State Suicide Prevention meetings.

The Kentucky Violent Death Reporting System (KVDRS) will continue to collaborate with public health through the CFR program as well as identify issues and at-risk populations, evaluates policies, and identifies topics for peer-reviewed publications and reports for DPH.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	70	55	56	58	59
Annual Indicator	54.9	54.9	56.5	58.9	58.7
Numerator	437	405	395	454	430
Denominator	796	738	699	771	733
Data Source		KY vital stats live birth cert files	KY vital stats live birth cert files	KY vital stats live birth cert files year 2010	KY vital stats live birth cert files year 2011
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	59	60	60	61	61

Notes - 2011
2011 data is preliminary and numbers could change.

KY has previously reported this indicator as VLBW born at any faciltiy with a neonatal intensive care unit, but after reexamining the indicator this year we have limited it to VLBW babies born only in a Level 3 center.

Data for 2011 NUMERATOR is number of very low birth weight (less than 1,500 grams) babies born at level III facilities to KY residents. Denominator is total very low birth weight babies born in state to KY residents.

Notes - 2010

2010 data is preliminary and numbers could change.

KY has previously reported this indicator as VLBW born at any faciltiy with a neonatal intensive care unit, but after reexamining the indicator this year we have limited it to VLBW babies born only in a Level 3 center.

Data for 2010 NUMERATOR is number of very low birth weight (less than 1,500 grams) babies born at level III facilities to KY residents. Denominator is total very low birth weight babies born in state to KY residents.

Notes - 2009
2009 data is preliminary and numbers could change.

KY has previously reported this indicator as VLBW born at any faciltiy with a neonatal intensive care unit, but after reexamining the indicator this year we have limited it to VLBW babies born only in a Level 3 center.

Data for 2009 NUMERATOR is number of very low birth weight (less than 1,500 grams) babies born at level III facilities to KY residents. Denominator is total very low birth weight babies born in state to KY residents.

a. Last Year's Accomplishments
Regionalized Neonatal Care: Currently Kentucky has two true Regional Perinatal Centers. University of Kentucky in Lexington, serving Eastern Kentucky, and University of Louisville/Kosair Children's Hospital in Louisville serving the Western half of the state. These centers offer comprehensive maternal-fetal and neonatal care, including outreach education, transport, and neonatal developmental follow-up, and a full range of obstetric, pediatric, and surgical sub-specialists. The Title V program contracts with these universities to assure all mothers and babies in KY have access to these services. There are two other hospitals in Louisville and one in Ashland with designated Level III neonatal beds. A total of 165 beds are licensed for care under the Level III designation. Due to geography, some KY high risk mothers and babies are also transferred to border facilities such as Vanderbilt University and Cincinnati Children's hospital. Additionally, 244 beds are licensed for care under the Level II designation; these hospitals are distributed throughout the state and provide varying levels of service, depending on whether or not they have been able to recruit neonatologist coverage, which is difficult in rural areas.

The Office of Certificate of Need (CON) within the Cabinet for Health and Family Services is responsible for working with local hospitals to approve numbers and levels of NICU beds. Currently, the Office of Health Policy encourages hospitals to apply for Level II NICU beds, as more beds in rural areas are seen as more accessible care. Applications include a statement that services will be consistent with the State Health Plan and National Guidelines for Perinatal Care, Sixth Edition, published jointly by the American Academy of Pediatrics and the American College of Obstetrics and Gynecology. However, once the CON is obtained, there is no reporting or oversight of these units. According to the State Health Plan, the number of Level III NICU beds is determined by a calculation based on the total annual births in the state while the number of Level II NICU beds is based by calculation using the number of total annual births to an area development district. Definitions for levels of care have not changed since originally established. Kentucky's State Health Plan was revised and adopted in May, 2011. As a result, regulation was enacted to change review criteria to allow facilities with existing special care Level II neonatal beds of utilization greater than 70% to add up to 4 beds.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Two Regional Perinatal Centers serving the state that offer comprehensive maternal-fetal and neonatal care; including outreach, education, transport, and neonatal development follow up.	X	X	X	X
2. Currently 244 beds in KY licensed for care under the Level II designation.	X		X	
3. Kentucky's State Health Plan revised and adopted in May 2011. As a result regulation was enacted to change review criteria to allow existing Special Care Level II neonatal beds in facilities with greater than 70% neonate care to add up to 4 beds.				X
4. Preconceptual health services through WIC, prenatal services, and folic acid program.	X	X	X	
5. Collaboration with Family Planning and preconceptual health counseling.	X	X	X	
6. Eduaction and technical assistance provided to LHDs on maternity and prenatal services.				X
7. Early entry into prenatal care encouraged statewide.	X	X	X	
8. Collaboration continues with the FIMR program in Lousiville to review systems of perinatal care at the local level.				X
9. Expansion of HBWW into 8 sites and corresponding LHDs & hospitals that engage in collaborative patient safety and QI activities.	X	X	X	X
10. The KY Office of Health Policy will join the KY IM team and participate in the HRSA Regional COIN on Perinatal Regionalization				X

b. Current Activities

Although the State Health Plan was updated in 2011, the Department for Public Health does not have responsibility for the State Health Plan nor the CON process, but continues to assist other Cabinet agencies with information as requested. DPH has continued to encourage the development of a Perinatal Quality Collaborative in the state. Kentucky has established a KY Group report in the Vermont-Oxford data system for those KY hospitals that choose to participate.

DPH continues to provide assistance and participation with the Louisville FIMR program. This program look at systems of perinatal care at the local level.
The Healthy Babies are Worth the Wait (HBWW) project has expanded and is now being implemented in 8 sites, including local health departments and hospitals that will engage in collaborative patient safety and quality improvement initiatives.

The Kentucky Perinatal Association has committed to developing a Kentucky Perinatal Quality Collaborative and is engaging partners in this plan.

c. Plan for the Coming Year

The KY Office of Health Policy has agreed to send representatives to the HRSA Collaborative Innovations Network for the Perinatal Regionalization workgroup. These representatives are now attending the KY Infant Mortality Team meetings as well. By participating in the COIN, they can learn directly about the best practices and what other states are doing with perinatal regionalization.

The Title V program, through contracts with the Regional Perinatal Centers, continues to engage university perinatal leaders to assist them in providing a leadership role in the establishment and ongoing maintenance of collaborative perinatal quality projects involving the hospitals in their regions.

DPH continues to collaborate with the National March of Dimes in the implementation of new HBWW sites throughout KY. DPH will also continue to support and engage in the development of the KY Perinatal Quality Collaborative through the Kentucky Perinatal Association.

The Kentucky Hospital Association has been contracted to serve as the Hospital Engagement Network (HEN) for this area, and is working with the Kentucky Perinatal Assocation on collaboring on the Obstetrical adverse events they are supposed to be addressing.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	80	75	76	73	74
Annual Indicator	72.4	72.5	69.2	73.4	75.2
Numerator	41103	39860	38480	38064	38170
Denominator	56749	55003	55628	51868	50764
Data Source		KY Vital Statistics Live Birth Certificate files	KY Vital Statistics files, live birth cert files	KY vital stats live birth cert files year 2010	KY vital stats live birth cert files year 2011
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	75.5	75.5	76	76	76.5

Notes - 2011
2011 data is preliminary and numbers could change.

Notes - 2010
2010 data is preliminary and numbers could change.

Notes - 2009
2009 data is preliminary and numbers could change

a. Last Year's Accomplishments

At the local level, all health departments have been certified in the Medicaid Presumptive Eligibility (PE) process to enable them to assist prenatal patients, who are eligible, to access temporary prenatal benefits at the time of the positive pregnancy test. PE is an eligibility tool adopted by Kentucky's Department for Medicaid Services to expedite a pregnant woman's access to needed outpatient prenatal services while their application for full Medicaid benefits is being processed. Information about PE is provided to LHD in the Public Health Practice Manual and and ongoing technical assistance is provided by the DPH.

Local health department staff provided counseling to pregnant women on the importance of early entry into prenatal care at the time of their positive pregnancy test, and appropriate referrals to the HANDS program. In addition, local health department staff made appointments or a referrals for the pregnant woman for prenatal services, as well as assisting Medicaid eligible pregnant women to access services. DPH continued to emphasize to LHD the importance of educating and assisting pregnant women to sign up for Presumptive Eligibility, Medicaid and/or the Prenatal Program at the time of a positive pregnancy test, as applicable per the policy and eligibility requirements.

Some local health departments have paid for prenatal services out of their community funds for uninsured pregnant women (i.e., the undocumented Hispanic population). This financial burden has been greater in some counties than others. The Division of Maternal and Child Health has attempted to alleviate some of this financial burden by allocating specified funds to the local health departments.

DPH did apply to be a CDC funded PRAMS state but was notified that funding for additional PRAMS state funding would not be available.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. All LHDs are certified in the Medicaid Presumptive Eligibility (PE) process to enable them to assist prenatal patients to access temporary prenatal benefits.	X	X	X	X
2. Ongoing education and technical assistance about PE to local health department staff by DPH.				X
3. DPH continues to educate and emphasize to LHDs the importance of education and assisting pregnant women to sign up for PE, Medicaid and/or the Prenatal Program.				X
4. Prenatal training available for all LHD nurses on DPH's TRAIN (Training Real-Time Affiliate Integrated Network) and annual live training.				X
5. HANDS Home Visitation Services during pregnancy and up to 12 weeks afer birth of infant.	X	X	X	
6. Tobacco Cessation Program for pregnant women including the Quit-Line.	X	X	X	
7. Centering Pregnancy Programs available at University of Kentucky and Trover clinics throughout the state. These centers provide prenatal and oral health care to pregnant women.	X	X	X	
8. DPH works closely with the Family Planning Program to assure referral to prenatal providers, for PE, Medicaid or the Prenatal Program. Data indicates an increase in women accessing prenatal care in the 1st Trimester.	X	X	X	
9. DPH will propose the FP waiver/SPA to extend family planning benefits to all women <185% FPL to the new CHFS Secretary	X	X	X	X

10.				

b. Current Activities
Information about PE is provided to LHD in the Public Health Practice Manual and ongoing technical assistance is provided by DPH. This information and process is emphasized at training provided to the LHD nursing staff.

LHD staff provide counseling to pregnant women on early entry into prenatal care. LHD staff make appointments or referrals for the pregnant woman for prenatal services. DPH continues to emphasize to LHDs the importance of educating and assisting pregnant women to sign up for PE.

DPH continues to work closely with the Family Planning Program to assure that women with positive pregnancy test are referred to a prenatal provider, as well as being referred for PE, Medicaid or the Prenatal Program. DPH provided ongoing technical assistance to the LHD to assure pregnant women are provided prenatal services. Provisional data indicates an increase in women accessing prenatal care in the first trimester.

The National Healthy Mothers, Healthy Babies Coalition (HMHB) launched text4baby, the first free health text messaging service in the U.S. Participating women receive free text-length health information and resources regarding pregnancy that are timed according to her due date. DPH continues to promote the "text4baby" program to the LHD and communities. Current data indicates that since the launch of the program in February 2010 through April 2012, KY now has 4,376 users enrolled.

c. Plan for the Coming Year
The new public health model in Kentucky will be to "Do or Assure" -- i.e., health departments will be encouraged to find community partners to provide clinical services, such as prenatal care, and link their patients to those services whenever possible, rather than duplicating. Title V will be supporting an MCH Coordinator in each local health dept to assist patients in getting them linked and into care with an appropriate provider.

DPH continues to educate and instruct the LHD to begin the referral process for prenatal care upon a positive pregnancy test. DPH will continue to educate the LHD staff about PE, Medicaid and the Prenatal Program process to help ensure early access to prenatal care. At the local level, all health departments have been certified in the Medicaid Presumptive Eligibility (PE) process to enable them to assist prenatal patients, who are eligible, to access temporary prenatal benefits at the time of the positive pregnancy test. PE is an eligibility tool adopted by Kentucky's Department for Medicaid Services to expedite a pregnant woman's access to needed outpatient prenatal services while their application for full Medicaid benefits is being processed. This information and process will be emphasized at the annual Prenatal and Postpartum Training provided to the LHD nursing staff. Information about PE will continue to be provided to LHD through the Public Health Practice Manual and ongoing technical assistance will be provided by the DPH.

The proposed Family Planning waiver for KY may improve birth spacing and preconception care, which could also have positive effects on this indicator if more pregnancies are planned.

Local health departments and communities will be encouraged to emphasize prematurity prevention and early entry into prenatal care through the use of the "Healthy Babies Are Worth The Wait" Prematurity Prevention Toolkit. LHD are encouraged to utilize this resource at community events to reach women of childbearing age and are provided information and HBWW tools at the LHD trainings.

DPH continues to promote the "text4baby" program to the LHD and communities.

D. State Performance Measures

State Performance Measure 1: *Percentage of first time births to Kentucky resident women aged 18 and older who had a pre-pregnancy BMI in either the overweight or obese category.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					50
Annual Indicator				50.5	50.8
Numerator				10913	10793
Denominator				21590	21238
Data Source				KY Vital statistics live birth cert files	KY Vital statistics files, live birth cert files
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	50	48.5	48.5	48	48

Notes - 2011
2011 data is preliminary and numbers could change.

Notes - 2010
2010 data is preliminary and numbers could change.

a. Last Year's Accomplishments
Information about appropriate prenatal weight gain and exercise in pregnancy is provided to Local Health Departments in the Public Health Practice Manual. LHD staff utilized this information to educate and counsel pregnant women. LHD staff can refer pregnant women to the nutritionist for Medical Nutrition Therapy who are overweight or have excessive weight gain. In addition, appropriate referrals are made to the HANDS program.

The data from the second PRAMS (Pregnancy Risk Assessment Monitoring Systems) pilot project is currently being analyzed.

Staff from DPH attended the 2011 Kentucky Perinatal Association Annual Education Conference. A presentation about Obesity and Pregnancy was included. This conference was also attended by physicians and nurses throughout Kentucky.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. DPH staff provide LHD staff with updates and guidance on how to educate and counsel pregnant women through annual trainings and in written documents.				X

2. LHD staff refer pregnant women to a nutritionist for Medical Nutrition Therapy who are overweight or have excessive weight gain.	X	X	X	
3. Annual prenatal training for LHD staffs includes information on maternal nutrition during and pre-pregnancy, exercise during pregnancy and weight gain during pregnancy for education of women receiving service in the LHDs.		X	X	X
4. KY Perinatal Association Annual Education Conference held in 2012 was attended by DPH and LHD staffs, as well as doctors and nurses across the state. Information was presented by Obesity and Pregnancy.				X
5. LHDs and communities are encouraged to use the "Healthy Babies Are Worth the Wait" Prematurity Prevention Tool Kit, available online and in hard copy.		X	X	X
6. DPH staff continue to analyze PRAMS data from previous pilot projects in regard to the sampling fractions & weighting of the data to include the number of childbearing age/pregnant women with a BMI in either the overweight of obese category.				
7.				
8.				
9.				
10.				

b. Current Activities

DPH provides annual training to LHD nurses and staff. This year's training included information on maternal nutrition during and pre-pregnancy, exercise during pregnancy and weight game during pregnancy according to standards of the IOM/ACOG. This information is then used by the LHD staff to educate and counsel women receiving LHD services.

Information about appropriate prenatal weight gain and exercise in pregnancy is provided to LHD in the Public Health Practice Manual. This information will be reviewed and updated to current ACOG standards.

DPH will provide an annual training to LHD nurses and staff. The training will include information on maternal nutrition during and pre-pregnancy, exercise during pregnancy and weight game during pregnancy according to standards of the IOM. This information is then used by the LHD staff to educate and counsel women receiving LHD services.

DPH is continuing to review the data from the second PRAMS (Pregnancy Risk Assessment Monitoring Systems) pilot project, particularly in regards to the sampling fractions and weighting of the data. Data that will be available will include the number of childbearing age/pregnant women with a BMI in either the overweight or obese category.

c. Plan for the Coming Year

DPH will continue to provide the annual 3 day training to LHD nurses and staff, which will include maternal nutrition, exercise and appropriate weight gain during pregnancy. This information is then used by the LHD staff to educate and counsel women receiving LHD services.

LHD and communities will be encouraged to utilize the "Healthy Babies Are Worth The Wait" Prematurity Prevention Toolkit.

DPH is continuing to review the data from the second PRAMS (Pregnancy Risk Assessment Monitoring Systems) pilot project, particularly in regards to the sampling fractions and weighting

of the data. Data that will be available will include the number of childbearing age/pregnant women with a BMI in either the overweight or obese category.

State Performance Measure 2: *Percent of Kentucky high school students who smoked cigarettes on one or more of the past thirty days.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					26
Annual Indicator				26.1	24.1
Numerator					
Denominator					
Data Source				KY Youth Risk Behavior Survey	KY Youth Risk Behavior Surveillance System 2011 su
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	25	25	24.5	24.5	24

Notes - 2011
Numerator and denominator data are not available.

Notes - 2010
Numerator and denominator data are not available.

The YRBS survey is only conducted in the odd years, therefore, data for 2010 is actually from the 2009 survey.

a. Last Year's Accomplishments
Students Taking Charge -- KY Action for Healthy Kids (KY AFHK) and the Coordinated School Health Team has provided professional development, technical assistance and funding to implement Students Taking Charge (STC) in 25 high schools across the state over the past two years. STC is a program for high school students to use their interest in nutrition and physical activity --- over all living healthy --- to help their school be a healthier place for everyone. With STC, youth get connected to their school and their school planning process to understand how to improve their school health environment. The high schools were selected through a request for proposals process. The STC assessment pieces (student, parent, and preview of the School Health Index surveys) were reviewed and changes made to reflect our work together and the CSH team's selected School Level Impact Measures; therefore they were "Kentuckized". Each school's student organization received a $500 mini-grant after they completed their three assessment pieces (student, parent, and preview of the School Health Index surveys) and local student action plan. The variety of student organizations participating include: FBLA, FCCLA, Student Council, Student Newspaper, HOSA, UNITE/SADD, Student Government, Beta Club, Legends and High School Walking Club.

As a result of the collaborative work on the described STC project, a core group of partnering organizations planned and hosted a STC Summit in October 2010 at Western Kentucky University. This was a collaborative effort between the CSH Team, KY Action for Healthy Kids, Western Kentucky University and National Action for Healthy Kids with additional financial

support through the Foundation for a Healthy Kentucky. The four main areas addressed at the Summit were: physical activity, nutrition, wellness policies, and advocacy. Sessions include: Advocacy for Change, Wellness Policy Review; Farm to School; Tobacco Prevention; Stress Reduction; Physical Activity Yoga and Dance, Drink Water First Campaign; Food Pyramid and Healthy Snacks. Overall, the summit was a success on many levels -- the speakers were informative & engaging, the students were enthusiastic, local media promoted the event -- both a radio drive-time interview and local TV segment, the university was a gracious host, the community partners were cooperative and the weather was perfect for traveling day. There were 50 high school students and 16 school sponsors in attendance from 11 high schools. The high schools represented were: Buckhorn, Caldwell Co. H.S., Carlisle Co. H.S., Christian Co. H.S., Clay Co. H.S., Jackson Co. H.S., Mercer Co. H.S., Owsley Co. H.S., Perry Co. H.S., Todd Co. H.S., Wolfe Co. H.S. Throughout the event it was exciting to watch the youth and sponsors connecting and developing ideas for future activities at their high school. Link to press article on STC Summit: http://www.wbko.com/home/headlines/104182064.html

The 100% Tobacco Free Schools (TFS) Work Group has been very busy with the 100% TFS model policy application process for school districts. To date, there are 23 school districts comprising of 121 schools that have in place a 100% TFS model policy. These schools have received school banners promoting and supporting their works for each of their schools through our application process. There are other school districts that are in different stages of the process of passing this policy through their school board. Due to the overwhelming demand, 100 new school banners have been purchased. These schools will be recognized and receive an award at the CSH Symposium this summer.

In June 2011 the Commissioners of Education and Public Health jointly signed a letter encouraging school district superintendent's to pass a 100% TFS policy. This letter has received much heralded support from the school community. School staff, local health department staff, school health advocates and others have used this document as an inroad to communicating with their local school administration and as a promotion tool.

The 100% TFS Work Group has updated all of the materials in the 100% TFS packet of information. The Asthma Prevention Program funded the reprint of the materials. The CSH Team jointly distributes these 100% TFS packets at all of our presentations and exhibits whether or not that is the particular subject at hand.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Ky Action for Healthy Kids & Coordinated School Health Team has provided professional development, technical assistance and funding to implement Students Taking Charge in 38 high schools during the 2011-2012school year.		X	X	X
2. The CSH program provides technical assistance and oversight of the STC program in participating schools.		X		X
3. Kentucky's 24/7 Tobacco Free Schools Partnernship focuses on support to school districts that have a comprehensive 24/7 tobacco free school policy.				X
4. The PANTA Plus Guide has been updated and will be distributed to school districts in 2012.				X
5. Collaboration continues between CSH and the Department of Education to improve school environments and policy concerning comprehensive 24/7 tobacco free campuses.		X	X	X
6.				
7.				

8.				
9.				
10.				

b. Current Activities
The Tobacco Prevention & Cessation Program (TPCP), National Action for Health Kids (AFHK), KY AFHK and CSH Team has had numerous communications concerning the addition of tobacco prevention as a strategy with the STC program. All partners worked collaboratively and creatively to make this concept something that can work for all programs involved. The TPP is in process of hiring a position which will work with youth related activities. This position will take the lead on developing the information to be included as a part of the current STC Facilitator's Guide.

PANTA Plus School Resource Guide 2011
The Physical Activity, Nutrition, Tobacco and Asthma (PANTA) Plus School Resource Guide was developed to update and expand in topic areas of the previous 2006 version. The Department for Public Health, Department of Education and Department for Behavioral Health, Developmental and Intellectual Disabilities partnered to provide the information in this updated and expanded guide.

This guide is in the process of being distributed through hard copy to key audiences as listed above as well promoted through conferences and presentations. The guide was printed with CSH and TPCP funds. Available on the web:
http://chfs.ky.gov/dph/mch/cfhi/Coordinated%20School%20Health.htm.

This guide has received attention from the Division of Population Health at CDC and is being shared with the Divisions located in the National Center for Chronic Disease Prevention and Health Promotion.

c. Plan for the Coming Year
KY Action for Healthy Kids (KY AFHK) and the Coordinated School Health Team has provided professional development, technical assistance and funding to implement Students Taking Charge (STC) in 38 high schools during this current school year. STC is a program for high school students to use their interest in nutrition and physical activity --- over all living healthy --- to help their school be a healthier place for everyone. Tobacco prevention is a topic area added to the current focus areas of physical activity and nutrition for the STC Program in Kentucky. Through continued communication and mutual compromise between National Action for Healthy Kids (AFHK), KY AFHK, CSH Initiative and Tobacco Prevention and Cessation Program (TPCP), Kentucky is a demonstration site for the addition of tobacco in their STC Facilitator's Guide this year. The STC Facilitator's Guide has been updated to include tobacco (green pages inserted throughout the document) prevention information.

There are 38 STC $500 mini-grants awarded to high school sponsored organizations this year. The focus areas represented are: tobacco -- 17, school garden -- 12 and physical activity/nutrition (other than school garden) -- 9. The variety of student organizations participating include: Future Farmers of America, Family Career Community Leaders of America, Service Learning Youth Councils, Students for Stewardship, Promoting Active Wellness in Students, Beta Club, Future Business Leaders of America, Teens Against Tobacco Use, Fellowship of Christian Athletes and Students Against Destructive Decisions.

Funding partners for this are CSH and the Tobacco Prevention and Cessation Program (TPCP). Collaborative partners for this process are: KY AFHK, TPCP and Alliance for a Healthier Generation. In January 2012 three mini-grant STC trainings were held with the applicants. Each HS organization performed an assessment of their school to help identify their needs (student, parent and mini-school health index surveys) and then completed and implemented an action plan. The HS organizations are in process of submitting their reports.

Over the past couple of years, the STC program has received local, state and national recognition through local media sources such as newspaper stories on the local STC group, Farm World Magazine article, Kentucky Farm Bureau media clip, CDC DASH success story, NACDD success story, presentations at the CDC-DASH Funded Partners (Fall 2010), TPCP's Spring Conference (Spring 2011), Jefferson County School System (Summer 2011), 5th Annual Southern Obesity Prevention Summit (October 2011) and upcoming CSH Symposium (June 2012).

State Performance Measure 3: *Percent of singleton live births to Kentucky residents that are 34-36 weeks (late preterm) at delivery.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					8.8
Annual Indicator				8.8	8.7
Numerator				4594	4426
Denominator				52097	50812
Data Source				KY Vital statistics, live birth cert files	KY Vital statistics files, live birth cert files
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	8.6	8.6	8.6	8.5	8.5

Notes - 2011
2011 data is preliminary and numbers could change.

Notes - 2010
2010 data is preliminary and numbers could change.

a. Last Year's Accomplishments
Each pregnant woman served through the Prenatal Program at the LHD is to be screened utilizing a preterm birth risk assessment at the initial visit/exam and at each return visit if at risk. Preterm birth prevention material is included in the Public Health Practice Reference for LHD staff to use for patient education. Additional information is available to the LHD to provide for patient and community education regarding preterm birth prevention, including preterm births at 34 -- 36 weeks gestation.
HBWW is a multi-dimensional, community-based approach to preventing preventable preterm births. Target audiences are health care providers, pregnant women, and the general public, as prematurity affects the entire community. The pilot program, which was conducted from 2006 to 2009, originally involved 6 communities: three intervention sites and three comparison sites. In 2010, the comparison sites became implementation sites along with the Barren River District HD and their two birthing hospitals. At the HBWW sites, community health leaders, including hospitals, health departments and local March of Dimes staff partner to work together to implement multiple interventions that are known to impact preterm birth; to improve systems of care in their community so that these interventions reach the patients who need them; and to promote awareness of preterm birth across all the community, including providers, patients and the public. Available on the website are materials which include the Prematurity Prevention Toolkit, which provides handouts, facts sheets, community activities and talking points for various

audiences, a power point presentation, a media guide and instructions on how to approach community partners.

The Kentucky Folic Acid Partnership (KFAP) is chaired by the Director for the Division of Maternal and Child Health, KY Department for Public Health, who presented at the 2011 KY Perinatal Association Annual Education Conference. The presentation "Healthy Babies are Worth the Wait" addressed preventable preterm birth, particularly in those infants of 34--36 week gestation. This conference was attended by physicians and nurses throughout KY.

One of the focuses of the KFAP is preterm birth prevention. The KFAP membership includes staff from LHD, hospitals and community agencies who are encouraged to provide health messages and community activities to promote preterm birth prevention.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. LHDs screen every pregnant women served utilizing a preterm birth risk assessment at the initial visit and at each return visit if at high risk.	X		X	X
2. LHD staff are provided educational materials to distribute to patients of child bearing age and communities.		X	X	X
3. HBWW toolkit is used to promote awareness of preterm birth through patient and community education & is available to HBWW sites and birthing hospitals.	X	X	X	X
4. HBWW sites, community health leaders, hospitals, LHDs, and local March of Dimes staff partner to implement multiple interventions known to impact pretem birth and improve systems of care in their communities.		X	X	X
5. KFAP members include LHD staff, hospitals and community agencies who encourage and provide health messages & community activities to promote preterm birth prevention.		X	X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Pregnant women served through the Prenatal Program at the LHD are screened utilizing a preterm birth risk assessment at the initial visit/exam and at each return visit if at risk. Preterm birth prevention material is provided for LHD staff to use in patient education, including preterm births at 34--36 weeks gestation.

DPH provided a free annual Prenatal and Postpartum Training for LHD staff that included information on prematurity and prematurity prevention. Each LHD was given the HBWW Brain Card, which lists comparative facts and a picture diagram of the brain at 35 and 40 weeks gestation.

The Kentucky Folic Acid Partnership (KFAP) is chaired by the MCH Director. One of the focuses of the KFAP is preterm birth prevention. The KFAP membership includes staff form LHD, hospitals and community agencies who are encouraged to provide health messages and community activities to promote preterm birth prevention. DPH worked closely with the KFAP and March of Dimes to update the HBWW Prematurity Prevention toolkit with current data and information.

Staff from DPH attended the 2011 Kentucky Perinatal Association (KPA) Annual Education Conference, which emphasized prematurity prevention. DPH continues to collaborate with the KPA on perinatal topics such as preterm birth prevention and the development of the KY Perinatal Quality Collaborative.

c. Plan for the Coming Year

The KY Hospital Association is serving as a Hospital Engagement Network site and will be working on hospitals to implement policies for elimination of elective deliveries < 39 weeks. This should also improve the rates of late preterm births. The KY Perinatal Association is collaborating with KHA on these activities in hopes of developing a KY Perinatal Quality Collaborative with this as the first project.

DPH is reviewing and updating the preterm birth risk assessment tool. Each pregnant woman served through the LHD Prenatal Program should be screened for preterm birth risk at the initial visit/exam and at each return visit if at risk. Additional information is available to the LHD to provide for patient and community education regarding preterm birth prevention, including preterm births at 34 -- 36 weeks gestation.

DPH will be providing a free annual Prenatal and Postpartum Training and Annual Update for LHD staff. Presentations will include information on prematurity and prematurity prevention. An overview of the HBWW Prematurity Prevention program will be presented. Each LHD will be provided with a Brain Card, which lists comparative facts and a picture diagram of the brain at 35 weeks gestation and 40 weeks gestation, to be used for clinic and community education.

November is Prematurity Prevention Awareness Month and DPH will plan to promote preterm birth prevention, particularly preventable preterm birth of 34 -- 36 week gestation through a variety of methods such as a media release, emphasis on the HBWW program and distribution of information and materials to the LHD.

The Kentucky Folic Acid Partnership (KFAP) is chaired by the Director for the Division of Maternal and Child Health, KY Department for Public Health. One of the focuses of the KFAP is preterm birth prevention. The Prenatal Program will continue to work closely with KFAP and will encourage the LHD to participate in the KFAP and provide community outreach activities related to preterm birth prevention.

State Performance Measure 4: *Proportion of Kentucky children birth to 5 years of age who die from child abuse.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					8.5
Annual Indicator				8.9	9.6
Numerator				25	27
Denominator				282367	282367
Data Source				DCBS case files plus death certificates	DCBS case files plus death certificate files
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance	9.5	9.5	9	9	8.5

Objective					

Notes - 2011
2011 data is preliminary and numbers could change.

2011 census data is currently not available and will not be until sometime late summer. Therefore, the denominator reflects population estimates from the 2010 census.

Notes - 2010
2010 data is preliminary and numbers could change.

a. Last Year's Accomplishments
In 2011, Prevent Child Abuse Kentucky has provided training for over 1,000 medical professionals. Specialized training has been developed for these medical professionals targeting children under the age of five years. This is addition to numerous other training events, all of which provide information regarding maltreatment of young children. PCAKY has also distributed over 44,000 brochures statewide to various organizations and health departments. A significant portion of these materials address Pediatric Abusive Head Trauma (Shaken Baby Syndrome) prevention---the largest cause of physical abuse death of young children. Prevent Child Abuse Kentucky in partnership with Kosair's Children's Hospital and University of Louisville, Department of
Pediatrics, and the Department for Public Health has been instrumental in the implementation of House Bill 285. This progressive legislation establishes training requirements for many professionals in the recognition and prevention of Pediatric Abusive Head Trauma. These programs provide support for their efforts to develop, operate, and expand a network of community-based, prevention-focused family resource and support programs that coordinate resources among a range of existing public and private organizations.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CFR collaborates with the KY Injury Prevention Research Center, Prevent Child Abuse KY and the Department of Community Based Services to bring awareness to mortality rates of children that die from abuse and neglect.				X
2. CFR and PCAKY focus efforts on child abuse prevention strategies targeting children birth to 5 years of age.			X	X
3. PCAKY trained over 1,000 medical professionals in child maltreatment issues such as Pediatric Abusive head Trauma.				X
4. DPH, PCAKY, Kosair's Children's Hospital , and U of L Department of Pediatrics were instrumental in the passage of HB 285 which establishes training requirements for professionals in the recognition & prevention of Pediatric Abusive Head Trauma.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Child Fatality Review and Injury Prevention program is collaborating with Kentucky Injury Prevention Research Center (KIPRC), Prevent Child Abuse Kentucky and the Department of

Community Based Services (DCBS) to bring awareness to the mortality rates of KY's children ages birth to 5 years old that die from child abuse and neglect. Representatives from all of these agencies are current and active members of the State Child Fatality Review Board and work together on presentations, trainings and community events held across the state of Kentucky. The Title V State funds allow the Child Fatality Review program to support state efforts to improve their practices in preventing and treating child abuse and neglect; and the Community-Based Services for the Prevention of Child Abuse and Neglect. The mission of Prevent Child Abuse Kentucky is to prevent the abuse and neglect of Kentucky's children. Children under age five are at greatest risk, and represent the majority of child deaths due to maltreatment. Therefore, Prevent Child Abuse Kentucky along with the CFR Program focuses much effort on prevention strategies targeting this age group.

c. Plan for the Coming Year

The proportion of Kentucky's children who died from abuse between the ages of birth and 5 years old is defined as a rate of per 100,000 children less than five years of age in KY. There was a slight increase from 8.9/100,000 in 2010 to 9.6/100,000 in 2011. The overall rate seems low but it is actually a total of 27 kids less than five years that died from abuse or neglect. In 2011 The Child Fatality Review Program will continue working with coroners to develop strong, active CFR Local Teams in order for them to recommend prevention strategies and implement safety changes and policies in their communities. PCAK will continue to provide critical prevention training and information, while expanding the focus on community based prevention strategies and Pediatric Abusive Head Trauma training and Child Maltreatment.

State Performance Measure 5: *Percent of 12-17 year old Kentucky residents reporting illicit drug use in the past month.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					12
Annual Indicator				12.3	8.1
Numerator					
Denominator					
Data Source				SAMHSA state specific data on illicit drug use	SAMHSA state specific data on illicit drug use
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	8	8	8	7.5	7.5

Notes - 2011

Numerator and denominator data are not available.

Notes - 2010

Numerator and denominator data are not available.

a. Last Year's Accomplishments

The KDE has an agreement with the Kentucky Center for School Safety (KCSS) for the provision of services as outlined in House Bill 330 by the 1998 Kentucky General Assembly, which created the KCSS. The mission of KCSS is to serve as central point for data analysis, research, dissemination of information on successful safety strategies, and technical assistance for safe schools. KCSS's distributes state allocated safe school funding to each school district. The KCSS also does the following:
Establishes a clearinghouse of information/materials on violence prevention;
Provides/Coordinates training, technical assistance, and program development to schools, law enforcement agencies, and communities; Analyzes school safety and discipline data reported by local districts; Evaluates existing school safety programs; Promotes interagency efforts to address school discipline and safety issues in collaboration with other post-secondary institutions and juvenile delinquency prevention councils; Provides annual report to Governor, Kentucky Board of Education, and Interim Joint Committee on Education on status of school safety in Kentucky; Advises the Kentucky Board of Education on administrative policies/regulations.

The 2009-2010 school year, was the last year that the KDE received Title IV (Federal Grant from the Office of Safe and Drug Free Schools) funding for schools. During the 2010-2011 school year, the Office of Safe and Drug Free Schools provided a competitive grant application process for the funding of 5-6 states to address safe and drug free schools. Kentucky did not receive this grant.

The Office of Drug Control Policy began collaborating with the Partnership for a Drug-Free America in March 2008 (and continues) for a statewide public service announcement (PSA) campaign to air professionally produced localized media message in a sustained effort to reduce the incidence of substance abuse in Kentucky. This includes PSA's in the local movie theaters which targets our children and youth and their parents.

Aggregate school data is collected every year from school districts broken down by disciplinary actions of "drug abuse" as a category. Further specific data is collected concerning drug possession and the drug type and then also drug distribution and drug type. Note that there are charts and a map if this would be of assistance -- let me know. This information can be found at: http://www.kysafeschools.org/data10.html under the 2010 report.
New link -- the above one does not work. Latest data is the 2010 report. Schools have to have their data in mid/late June. https://www.kycss.org/data10.php

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Aggregate school data is collected every year from school districts broken down by disciplinary actions of "drug abuse" as a category.				X
2. DPH Coordinated School Health Program collaborates closely with Kentucky Department of Education in addressing illicit drug use in youth.				X
3. DPH's LHD nurses are trained to perform pediatric and adolescent well child/EPSDT assessments in which they screen for family history and patient physical indicators of substance abuse.	X		X	X
4. DPH nurses provide anticipatory guidance for tobacco, alcohol and drug health risks and facts, making appropriate referrals for mental health and substance abuse.	X		X	X
5. KDE collaborates with the Kentucky Center for School Safety (KCSS) to analyze data, research and disseminate information on successful safety strategies.				X

6. The KCSS recently added prescription drug use as a technical assistance opportunity for schools and will train particpants on ways schools can protect children from the dangers of prescription and over the counter drug abuse.				X
7.				
8.				
9.				
10.				

b. Current Activities

DPH's Coordinated School Health (CSH) Program collaborates closely with the Kentucky Department of Education (KDE). The KDE collects annual aggregate school data broken down by disciplinary actions of "drug abuse" as a category. Further specific data is collected concerning drug possession and the drug type and then also drug distribution and drug type. This information can be found at: http://www.kysafeschools.org/data10.html under the 2010 report. New link -- the above one does not work. Latest data is the 2010 report. Schools have to have their data in mid/late June. https://www.kycss.org/data10.php

Local health department nurses are trained to perform well child/EPSDT pediatric and adolescent preventive assessments in which patients are screened for family history and patient physical indicators of substance abuse. During the assessment anticipatory guidance is provided for tobacco, alcohol and drug health risks and facts. Appropriate referrals are made for mental health/substance abuse services.

c. Plan for the Coming Year

The KCSS has recently added prescription drug use as a technical assistance (TA) opportunity for schools. The trainer for this TA will provide participants with ways that schools can protect our kids from the dangers of prescription and over the counter drug abuse. Also, the trainer discusses where we are now and what can be done daily to achieve our goals in this health risk area.

State Performance Measure 6: *The number of Medicaid covered women who had at least one dental visit during their pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	28	34	34	35	35
Annual Indicator	32.3	33.3	33.2	32.5	32.5
Numerator	11972	12332	12481	12162	12140
Denominator	37053	36988	37648	37438	37392
Data Source		KY Medicaid claims data warehouse	KY Medicaid claims database	KY Medicaid claims database	KY Medicaid Claims database
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**

Annual Performance Objective	36	36	37	37	37.5

a. Last Year's Accomplishments

The University of Kentucky College of Dentistry continues the implementation and augmentation of the Centering Pregnancy programs at the Women's Health Center at the Trover Clinic in Madisonville and at the University of Kentucky. The Centering Program provided prenatal education and care for expectant mothers in small, peer-lead groups. Running concurrent to the group sessions are dental care appointments for the participants adjacent to the meeting room. Dental care for these women had emphasis on professional prophylaxis and stringent home care. Referrals for more complicated procedures were made as needed. Their goal continued to be 1000 participants each year. Centering Pregnancy is a national model, developed and tested by Yale University, with positive effects on birthing outcomes. Developments in Kentucky are coordinated with the continuing March of Dimes Initiative and the Department for Public Health.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. KY continues the implementation & augmentation of the Cntering Pregnancy programs at the Women's Health Center at Trover Clinic and UK.	X	X	X	X
2. Education and dental care for pregnant women at the Centering Pregnancy programs emphasize professional prophylaxis and stringent home care.	X	X	X	X
3. The KOHP continues to collaborate with community partners to improve oral care access throughout the Centering Pregnancy with Smiles curriculum.	X		X	X
4. Continued collaboration of KOHP, DPH Prenatal Program, and Medicaid to provide materials and education to public and private healthcare providers on optimal oral health during pregnancy.				X
5. Continued outreach activities for dental screening and oral care of pregnant women across Kentucky.	X		X	X
6. Kentucky's Medicaid program continues to include full mouth debridement for pregnant beneficiaries as a covered service.	X		X	
7.				
8.				
9.				
10.				

b. Current Activities

The Kentucky Oral Health Program continues to collaborate with community partners to improve the access to oral health care for pregnant women through the Centering Pregnancy with Smiles curriculum. These partners include Frontier Nursing Services at Hyden, the University of Kentucky Center for Rural Health in Hazard, the Women's Health Center in Madisonville's Trover Clinic and the University of Kentucky College of Dentistry.

According to Medicaid data for the CY 08, more than 33% of pregnant women eligible for Medicaid services received a dental service. This is increased from 32% for the last year.

c. Plan for the Coming Year

The Kentucky Oral Health Program will collaborate with the Kentucky Department for Public Health's Prenatal Program and Medicaid to provide materials and activities targeting both the public and private health care providers regarding the importance of optimal oral health during pregnancy and throughout one's lifetime. Included in this effort are:

-continued partnership with the University of Kentucky College of Dentistry and their work with the Centering Pregnancy With Smiles program and curriculum in the western part of the Commonwealth as well as its expansion to other areas of the state. Centering Pregnancy with Smiles is planned for implementation in the summer of 2009 through the University of Kentucky's College of Dentistry's new partnership with the St. Claire Regional Health System in Morehead, Kentucky.

-through outreach activities, the Kentucky Oral Health Program will continue to encourage dental screening and needed oral care for pregnant women in the Commonwealth.

-through a unique opportunity with the University of Louisville's Medical School and Dental School, the Kentucky Oral Health Program attempt to catalyze the development of a curriculum that will assist obstetricians in the importance of routine and comprehensive dental care in the pregnant patient as well as education and training for the dental professional in the safe and effective management and treatment of the pregnant patient during the prenatal months to optimize the chances of a successful delivery and healthy baby.

-continued dissemination of pertinent studies and educational material to a list serve of identified oral health contacts in the local health departments.

-Kentucky's Medicaid Program will continue to include full mouth debridement for pregnant beneficiaries as a covered service.

State Performance Measure 7: *Decreased percentage of children, ages 0 to 18, receiving CCSHCN services, with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					32
Annual Indicator				35.2	36.7
Numerator				596	1585
Denominator				1693	4321
Data Source				CCSHCN CUP database	CCSHCN CUP database
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	35	34	33	32	31

Notes - 2011
SPM 7:
Numerator (0-18 CCSHCN-enrolled with BMI>=85% as of 6/30/11)
Denominator (0-18 CCSHCN-enrolled with a BMI measurement as of 6/30/11)

a. Last Year's Accomplishments
Toward the goal of reducing the documented disparity between Kentucky CYSHCN and non-CYSHCN, CCSHCN implemented its Healthy Weight Plan in May, 2011. The plan, aimed at

reducing the proportion of CYSHCN who are at risk for being overweight or obese, and developed by a multidisciplinary and geographically diverse group of CCSHCN staff from all levels of the organization, includes action in the areas of prevention, identification, and intervention/treatment.

The annual indicator on SPM 7 has inched up from 35.2% to 36.7%. This has not gone unnoticed; the Healthy Weight Committee is aware of the increase and feels that this year's indicator may be a reflection of a truer baseline than last year, as full implementation of BMI tracking did not occur during 2010 (as is reflected in the increasing denominator). During SFY 2011, 68% of respondents (over 1000 families) to comment on clinic survey cards indicated that CCSHCN staff discussed healthy eating and nutrition with them.

2011 marked the rollout of CCSHCN's Healthy Weight initiative, including at its core, BMI tracking and individual health education, and the dissemination of health promotion materials to the CYSHCN population -- a group who often find it more difficult to control weight and remain healthy. CCSHCN encourage healthy eating and physical activity, and reduced "screen time" through a 5-2-1-0 campaign. Many CCSHCN offices have employed an active scavenger hunt activity/game to reinforce the message; all offices/clinic environments are adorned with 5-2-1-0 posters and signs and stock trusted materials for patients, such as Chop-Chop magazine, articles from "Healthy & Fit", "Healthy Favorites", brochures from Jump Up and Go, and other media from sources like Bright Futures or "Let's Move".

Patients and CCSHCN physicians were provided with information on the new Healthy Weight initiative, and CCSHCN nurses were provided with talking points and "individualizable" letters to send with families of CYSHCN at or above the 85th percentile to their primary care physician or medical home -- regarding treatment of obesity and obesity-related health problems.

A second dietitian was added in 2011 to CCSHCN's staff; dietitians housed in Lexington and Louisville are now available to attend clinics in the Eastern and Western halves of the state, respectively. Dietitians are available for consult at any time by any CCSHCN staff member. On a macro level, CCSHCN's dietitians attended several hearings of the Kentucky Legislature's Task Force on Childhood Obesity during the 2011 interim General Assembly session. These hearings were initiated by policy-makers to study strategies for addressing the problem of childhood obesity and to recommend strategies for addressing the problem. The hearings culminated in a report issued in December, 2011, recommending several strategies that encourage better nutrition and increased physical activity among children. Among the strategies highlighted during the hearings was the 5-2-1-0 approach, which has been implemented by CCSHCN and other organizations.

CCSHCN's Healthy Weight initiative maintains its materials on a page on the agency's intranet site, and periodically, messages or additional resources are shared with the public via the agency's Facebook social media site. Behind the scenes, CCSHCN administrative staff made the technology modifications to measure BMI-for-age percentiles necessary for reporting.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Participation in councils supporting DPH's CDC Obesity Prevention Grant.				X
2. Encourage healthy eating & physical activity and reduced screen time, during clinic, through 5-2-1-0 message.	X	X		
3. BMI screening & percentile plotting of CYSHCN during or after clinic.	X			
4. Development of CUP queries to determine baseline & ongoing		X		

data describing at-risk population.				
5. Counseling of at-risk patients on medical effects of childhood obesity & predisposition to adult diseases, and referral to CCSHCN dietitian.	X	X		
6. Referral to health professional trained in weight management, where available, or to primary care physician on initiative of patient.	X	X		
7. Provision of health education and health promotion materials to at-risk youth in specific and CYSHCN population in general.	X	X		
8.				
9.				
10.				

b. Current Activities
Staff continue to calculate BMI, plot BMI percentile on growth charts, and counsel on the medical effects of childhood obesity when indicated. Staff may provide "prescriptions for physical activity", refer to CCSHCN dietitians and/or health professionals trained in weight management. Therapists engage patients in physical activities per their needs. Unfortunately, staffing, time, and space issues prohibit structured activity with groups in clinic or waiting room settings.

CCSHCN is committed to addressing healthy weight with CYSHCN and their families. Many barriers exist; lack of time during appointments, readiness to make changes, or acceptance that overweight/obesity is a legitimate concern; families who are more concerned with their children's special health care need(s) than they are about the risks of overweight or obesity. CCSHCN makes gentle efforts to overcome these barriers, and works with others to advance solutions to community concerns beyond the scope of the agency

A component of the Healthy Weight Plan concerns prevention. CCSHCN participates in larger efforts to address the obesity epidemic. Given the tradition of interagency partnership, and the recognition of the societal nature of problem and that no one agency can solve the problem, many CCSHCN regions are participating in regional councils supporting the Department for Public Health's obesity prevention initiatives. CCSHCN is also represented on the statewide Partnership for a Fit Kentucky.

c. Plan for the Coming Year
During the coming year, CCSHCN intends to assess staff comfort level with and buy-in to the initiative, and continue to develop staff capacity to address healthy weight issues. Planned activities include outreach by the Healthy Weight committee members to field supervisors and staff and follow-up on issues in statewide managers's meetings and through in-person and e-mail communications. Depending on the assessed need, CCSHCN's Healthy Weight Committee may create a continuing education opportunity or use an existing one. Staff physical activity/weight loss challenges to engage nurses on these issues are also a possibility.

Making dietitians available to CCSHCN clinics outside their home regions of Lexington and Louisville will be continued whenever possible. However, the practice of "tasking" the dietitians to make cold calls to at-risk patients has not met with a positive response. Alternate methods of intervention will be explored. Information system reports which identify patients with elevated BMIs who are coming to clinic in the next month will be sent out to the regional offices, and processes will be put in place so that CCSHCN staff know to counsel these patients and their families at clinic. Positive reinforcement strategies will be considered, for example, sending "congratulations" letters to patients who were at or above 85% of BMI and subsequently fall below 85% has been discussed, as has a quarterly award for the CCSHCN region who make the most outstanding efforts toward healthy weight counseling and education. The Healthy Weight committee will study data available regarding how rates of overweight/obesity vary across clinics

and age groups, and may recommend targeted outreach as indicated. Inclusion of healthy weight intervention as a criteria in management audits of patient charts is an option which has been discussed The committee will continue to meet regularly and evaluate the implementation of the plan and progress/lack of progress toward improved indicators on this SPM.

State Performance Measure 8: *Degree to which CCSHCN transition action plan is successfully completed and implemented.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					55
Annual Indicator				46.2	63.5
Numerator				24	33
Denominator				52	52
Data Source				CCSHCN Transition Action Plan Ratings	CCSHCN Transition Action Plan Ratings
Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	60	70	80	90	95

a. Last Year's Accomplishments
During the past year, CCSHCN's Transition Action Plan committee, oversaw continued implementation of the agency's 13-point, 5-year plan. The committee is chaired by the Transition Coordinator and includes members of both administrative management and field-level clinical services representatives. The committee met several times during the reporting period to share progress, as much of the work was achieved in subcommittees. This year's total score on the plan of 33 out of a possible 52 points marks a sizable improvement over the baseline total score last year of 25 out of a possible 52 points.

Update by plan number listed on detail sheets:
1. Activities are progressing. Much of CCSHCN's work toward transitions centers around the transition checklist, a milestone-based guide that prompts care coordinators to address transition points with CYSHCN and their families. .
2. Activities are sustained. Outreach was implemented during the previous reporting period. Letters soliciting feedback have been revised due to low response. .
3. Activities are progressing. While some aspects of this goal have been completed (an intranet social service resource page for CCSHCN staff, updates to the agency website and Facebook page regarding community education events), the public resource guide portion is currently on hold pending the outcome of goal number 1 with regard to the transition checklist update.
4. Activities are progressing. Transition surveys, clinic mini-surveys (comment cards), and revised transition checklists are used to measure the impact of transition efforts. Transition surveys and clinic mini-surveys are established. Tthe committee is awaiting full implementation of the transition checklist prior to generating more data to measure transition efforts.
5. Activities have just begun. The Kentucky Integrated Services for CYSHCN (D70) steering committee has begun discussion regarding possible plans in this area. Kosair Children's Hospital has started discussing with physicians and gaining commitment regarding their role in transitions services.
6. Activities are sustained. The Youth Advisory Council (YAC) role has steadily increased to the point where it has evolved into an effective and relevant advisory body. Activities during the past

year include the creation of a topical tipsheet for distribution by CCSHCN staff to CYSHCN, provision of helpful input on draft agency transition forms, and presenting on transitions at a gathering of educators.
7. Activities are progressing. The committee feels that each element and the entire transition plan represent the agency's effort towards revised procedures to conform to the best practice consensus statement.
8. Activities are well-established. An updated agency policy was issued during the previous reporting year. Chart audits are conducted, using a tool incorporated in agency policy, to ensure that CYSHCN are signing their medical forms. Chart audits are a part of CCSHCN care coordinators' performance evaluation.
9. Activities are well-established. CCSHCN staff currently provides support to patients regarding accommodations available to enable management of healthcare issues in educational settings. The YAC and the Parent Advisory (PAC) have developed companion tipsheets (from youth and parent perspectives, respectively), which serve as resources for providing recommendations for advocating for one's needs to request accommodations in educational settings. CCSHCN care coordinators document in their service notes activities they provide to support parents in managing healthcare issues in the school system. Family consultants and F2F support parents provided one-to-one and professional support to families of CYSHCN regarding management of issues in the educational setting.
10. Activities are progressing. As mentioned above, the revised transition checklist has been revised and piloted, and will be going into production shortly.
11. Activities are progressing. CCSHCN's social media presence includes an agency Facebook page which previously was dormant.
12. Activities are progressing. CCSHCN staff currently counsels patients, provides assistance with the selection of adult health care providers, and encourages meetings with the selected providers prior to discharge.
13. Activities are sustained. CCSHCN currently initiates transmittal of medical records (with release) to adult medical providers upon discharge or identification, when the selected physician is known.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Refine transition checklist for families and CYSHCN.		X		X
2. Initiate tangible outreach to all CCSHCN clients upon 14th, 16th, and 18th birthdays, including surveys/assessments of current levels of independence and preparation for school/work.		X		X
3. Cultivate awareness on available community resources through public resource guide, intranet social service page for staff, community education events.		X		
4. Develop and implement systems to measure impact of transition efforts and policies.				X
5. Establish and distribute training documents in a variety of settings for providers regarding their roles in the transition process.				X
6. Increase visibility and active involvement of CCSHCN Youth Advisory Committee.		X		X
7. Revise agency procedures to conform to best practice consensus statement on health care transitions for CYSHCN.				X
8. Initiate CCSHCN procedure encouraging children's signature on medical forms starting at age 12.	X			
9. Provide support to CYSHCN regarding accommodations available to enable management of health care issues in		X		

educational settings.				
10. Create a written health care transition plan by age 12 for CCSHCN children.				X

b. Current Activities
Revision of the agency's transition checklist represents an important achievement toward enhancing CCSHCN's ability to better serve the transition needs of CYSHCN. Full implementation of the revised transition checklist is occurring. As revisions are considered, the Transition Action Plan Committee continues to oversee the implementation of a variety of other transitions-related initiatives. Birthday letters, active involvement of the YAC and the transmittal of medical records to adult medical providers are established elements of CCSHCN practice; however, other plan elements are in various states of progress (see above) and continue to receive agency attention.

c. Plan for the Coming Year
Please see above; CCSHCN continues to address the elements of the five-year plan, focusing on those items which are progressing, followed by those elements on which work has not yet begun.

E. Health Status Indicators

KY evaluates and monitors many of our MCH efforts through our Health Status Indicators. In selecting the new state priorities, the Health People (HP) 2020 goals have provided a fabric upon which the state can weave the health complexities KY experiences into a pattern communities can understand and work to develop prevention objectives. The data and prevention strategies play an integral role in responses to state officials as we demonstrate how our efforts move us closer to our health goals.

It is important to note that, even though KY lies within a region of high infant mortality and child injury and death rates, the state is actively involved in a number of projects to address these issues. DPH contracts with UK utilizing the expertise of the Kentucky Injury Prevention Research Center to interpret data, educate communities and public officials, and provide additional resources to prevent child injury and death. In conjunction with Regions IV and VI, the state has embraced the regional initiatives to reduce infant mortality, with emphasis on activities to reduce births before 39 weeks gestation and promoting health care to all children and women who are pregnant and of child bearing age.

Health Status Indicator 01A: The percent of live births weighing less than 2,500 grams.
Health Status Indicator 01B: The percent of live singleton births weighing less than 2,500 grams.

Insights from our PRAMS pilot are informing our efforts for this longstanding MCH issue. Our focus for interventions has been the overlapping problem of preterm birth. WIC continues to be one of our strongest interventions and in this economy, is serving record numbers of mothers and infants. KY was one of the first states to implement the new food packages and is expanding the WIC Farmer's Market Program so that additional participants can access fresh fruits and vegetables. The VENA approach (Vale-Enhanced Nutrition Assessment) is a more client-centered, motivational interviewing type approach and should be more effective in addressing the barriers of pregnant mothers to good nutrition. Since food insecurity is one of the major sources of chronic stress in pregnancy, the WIC program plays a major role as a protective factor and reduces that stress.
Smoking has a huge impact on the LBW rates in KY.

LHDs assess every pregnant woman for use of alcohol, tobacco, and secondhand smoke exposure, providing education and referrals when indicated. Group cessation is offered or

referred in most settings, free of charge and in English and Spanish. The Kentucky Quit Line is available to everyone.

Participants in the HANDS home visiting program, according to independent evaluators, also have less low birth weight infants than a comparison group. This program is most successful when mothers get enrolled early in the pregnancy and get 16 or more visits. This is a strength based program that addresses social as well as health issues, and builds skills and resilience in the pregnant mother for dealing with her life situation, however stressful it may be. The holistic approach including the social determinants of health may explain the positive impact on Low Birth Weight, which over the last several decades has been relatively resistant to medical interventions alone. We look forward to enhancing this program with new home visiting grants from health care reform.

KY's trend for LBW has been stable. Of the LBW rates, 9% are from LBW and 1.5% are VLBW. DPH continues to work with LHD to emphasize the importance of educating women on the importance of early prenatal care and improved birth outcomes.
DPH contracts with the two Regional Perinatal Centers in Kentucky, which offer provision of comprehensive perinatal health services at or above those of subspecialty care facilities. This includes Level III B & C neonatal critical care, neonatal developmental follow-up, transport services, outreach education and quality improvement.

DPH conducted a second PRAMS (Pregnancy Risk Assessment Monitoring Systems) pilot project following the guidelines from the Centers for Disease Control and Prevention (CDC) PRAMS core and standard questionnaires, including questions on access to care. Approximately 1600 surveys were sent out and sampling was conducted from March through October 2009 and 844 women who were recently pregnant responded. Of the 844 recently pregnant women who responded, 96.3% of mothers sought prenatal care during their pregnancy, but 14.4% were unable to get care as early as they wanted. Health care reform may improve this situation. Currently, PRAMS data from the second pilot is being evaluated.

Health Status Indicator 02A: The percent of live births weighing less than 1,500 grams

This trend has been stable and the most recent data indicates a decrease in KY. This is consistent with our studies of preterm birth, where the rising rates were not predominately from extreme prematurity, but from late preterm births.

For Health Status Indicator 02B, the preliminary data appears to show improvement, but it is too early to tell.

LHD staffs continue to counsel pregnant women on the importance of early entry into prenatal care at the time of their positive pregnancy test, and make appropriate referrals to the HANDS program. All pregnant women receiving services at LHDs are screened at each visit for the use of alcohol, tobacco and drug use, as well as exposure to secondhand smoke, and educated about preterm birth, nutrition, weight gain, exercise and dental care.

KY has a Fetal & Infant Mortality Review (FIMR) program with a local FIMR team in Louisville, which has our highest African-American population. We hope this will provide new insights and strategies on factors that lead to VLBW. Fetal and infant deaths from 24 weeks gestation through 1 year of age are reviewed. Louisville is also the site of a Federal Healthy Start program which has been successful in reducing LBW in their population, and the Infant Mortality project by the DHP Office of Health Equity, which is looking at contextual and neighborhood factors around LBW, IM, and Preterm birth.

In the HANDS home visiting program, evaluations have shown almost no VLBW infants when mothers enter the program in the first trimester and engage with 16 or more visits (visits are weekly during pregnancy). There are no medical interventions that could produce this effect,

reinforcing our belief that interventions must address social determinants as well as medical aspects of health.

Medical studies are providing new interventions which reduce VLBW. Folic acid has been shown in some studies to reduce early prematurity by 50-70%. Thus the efforts of the KY Folic Acid Partnership and the Folic Acid program in health departments and the Commission have renewed importance in the opportunity to improve birth outcomes. In addition, progesterone given mid-pregnancy for women at risk shows promise in reducing early preterm/VLBW infants, especially if used in combination with measurements of cervical length to determine which women are at risk. One of the leading researchers for this national study is an advisor to the KY Healthy Babies are Worth the Wait project and the Title V program. Lack of coverage is a barrier to getting women into early prenatal care which could prevent some of these VLBW deliveries. In addition, some studies have shown significant impact in reducing a second very premature birth/VLBW by identifying women with a previous preterm birth and providing them access to care (medical card) and case management for 24 months after the preterm birth. Health care reform may provide opportunities to develop better programs that would allow these interventions on a regular basis for pregnant women, which could result in improved birth outcomes and fewer VLBW infants.

DPH contracts with the two Regional Perinatal Centers in KY, which offer provision of comprehensive perinatal health services at or above those of subspecialty care facilities. This includes Level III B & C neonatal critical care, neonatal developmental follow-up, transport services, outreach education and quality improvement.

Health Status Indicator 03A: The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.
Health Status Indicator 03B: The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.

Kentucky has seen a decrease in its death rate of unintentional injuries among children aged 14 and younger.

DPH's HANDS program staffs educate parents on injury prevention strategies such as Safe Sleep to prevent SIDS and co-sleeping fatalities. LHDs utilize many injury prevention strategies to educate their patients/families and the community in an effort to reduce the number of fatalities due to drowning, fire, and poisoning.

The State Child Fatality Review Team has benefited by collaboration with Chief Medical Examiner, Dr. Tracey S. Corey and Dr. Melissa Currie, KY's only Forensic Pediatrician. These collaborative efforts have heightened awareness of prevention strategies in the areas of SIDS and child maltreatment prevention through increased interaction with the State CFR Team and groups such as the Kentucky Coroner's Association.

Annually the State Child Fatality Review and Injury Prevention program publishes a report which includes information on injury prevention strategies that is distributed to the Governor, Chief Justice of Kentucky Supreme Court, and the Legislative Research Commission, LHDs, the county coroners, and posted on the program's website. The Child Fatality Review and Injury Prevention program in the Division within DPH and DCBS Child Safety Branch have begun a collaboration to strengthen child maltreatment prevention strategies. DPH continues to work with Safe Kids Kentucky, the Kentucky Injury Prevention and Research Center, the National Violent Death Reporting System and partners of the like to increase education on prevention strategies.

Dr. Susan Pollack, Director, Pediatric and Adolescent Injury Prevention Program for KIPRC, participated as one of 60 stakeholders in the development of the National Action Plan for Child Injury Prevention. This plan includes goals to raise awareness about child injury and its effects on the nation, solutions based upon a common set of goals and strategies, and ways to mobilize action to reduce child injury and death. The plan is included in the CDC Vital Signs report.

In 2011, education and support for child passenger safety was provided to more than 5000 people. KY's rates have shown a steady decrease for the past 3 years, with the 2011 rate being the overall lowest in the past 7 years.

See National Performance Measure 10 for more information on KY initiatives to decrease injury for children due to motor vehicle crashes.

Health Status Indicator 03C: The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.

The death rate of unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years in KY has shown a slight increase. This has been the first time in 5 years that KY has shown an increase for this age group. The Injury Prevention Program will continue to work with legislation to promote stronger laws and regulations for young KY drivers. KY has the primary seat belt law that was passed in the last 6 years and the Graduated Driver's Licensing (GDL) law. This law, passed in 2006, aims at educating our youth on safe driving habits. These education efforts continue even today and include getting the word of GDL into schools and to parents. HB 415 includes provisions to prohibit text messaging, instant messaging, and e-mailing while operating a motor vehicle. It also prohibits cell phone use while driving if the driver is under eighteen years of age.

Health Status Indicator 04A: The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.
Health Status Indicator 04B: The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.

The Injury Prevention program will continue working with DPH's HANDS program staff to educate parents on injury prevention strategies and assists them in completing a home injury prevention checklist to heighten parents' awareness of possible hazards in their home. The Healthy Start in Childcare Program aids childcare centers in identifying playground hazards.

The Childhood Lead Poisoning Prevention Program decreases unintentional injuries through the LHDs educating parents on lead poisoning prevention strategies regarding safe toys and other hazards. The Well Child and School Health programs aide in educating school based staff on creating a safe environment for children within the school.

LHDs utilize many injury prevention strategies to educate their patients/families as well as the community in an effort to reduce the number of injuries.

For further information on KY child abuse prevention efforts please see State Performance Measure 2.

Annually the State Child Fatality Review and Injury Prevention program publishes an annual report which includes information on injury prevention strategies that is distributed to the Governor, Chief Justice of KY Supreme Court, and the Legislative Research Commission, local health departments, the county coroners, and posted on the program's website.

See National Performance Measure 10 for more information on KY initiatives to decrease injury for children due to motor vehicle crashes.

Health Status Indicator 04C: The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.

See Health Status Indicator 03C above for Kentucky initiatives that address this indicator.

Health Status Indicator 05A: The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.
Health Status Indicator 05B: The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.

Between January 1, and December 31, 2011, Kentucky received 16,635 reports of chlamydia compared to 16,376 reports during the same time period in 2010. This resulted in an increase of 259 cases or 2%. The small increase in chlamydia during 2011 is believed to be due to continued improvement in reporting and STD surveillance.

The overall positivity rate of prevalence monitoring data in 2011 was 8.1% compared to 7.6% during the same time period of 2010. In addition, reports from the private sector increased by 4.7% while reports from public providers of STD services decreased by 5.0%. Seventy-five percent of the chlamydia cases were reported from 20 counties. The county reporting the largest number of chlamydia cases in 2011 was Jefferson County (Louisville). Jefferson County reported 31% (5,125 cases) of the state's total chlamydia cases which resulted in a case rate per 100,000 populations of 710.2. Fayette County (Lexington) reported 1,418 cases (478.2 case rate/100,000) which was the second largest number of reports and accounted for 9% of KY's total chlamydia morbidity. The third and fourth highest number of reports (591 & 527) came from Kenton and Hardin Counties.

Between January 1, and December 31, 2011, 6,515 reported cases were among Whites, 4,895 were among African Americans, 481 were among Hispanics, 51 were among Asians, and 29 were among American Indians. Since morbidity for reportable STDs is often obtained from laboratory results submitted by commercial laboratories which often lack information about patient ethnicity, there were 4,669 reported cases for which race/ethnicity was not stated. As is the case with gonorrhea, the incidence rates based on race or ethnicity show that minorities are the most adversely affected by chlamydia disease. The incidence rate for chlamydia among all minorities was 1107.0 per 100,000, compared with 173.1 for Whites. The incidence rate for African Americans was the most disproportionate with a case rate of 1472.5 per 100,000.

The distributions of cases by age are as follows: 5,833 reports (35% of the total) were among persons less than 20 years of age. The age group reporting the largest number of cases was 20 - 24 year olds which accounted for 6,552 reports (39% of the total); 2,401 (15%) cases were reported among individuals within 25 -29 years of age; 1,849 (11%) cases were reported among individuals 30 years of age and over.

F. Other Program Activities

Other MCH Priorities/Program Activities

The Division MCH is the state agency responsible for administering KY's Title V program and provides the toll-free hotline mandated by the federal government to provide access to information for parents regarding health care providers and practitioners who provide health care services and other relevant health-related information for Title V and Title XIX services. The hotline is answered within the Child and Family Health Improvement Branch of MCH. Callers receive a live voice during normal business hours and may leave a voice message when the office is closed. Calls are returned as soon as possible.

Callers are directed to appropriate program staff when indicated. For instance, calls related to WIC are transferred to the WIC program coordinator in the Nutrition Services Branch; mammogram and women's cancer inquiries are transferred to the Women's Health Division.

Prenatal inquiries are handled by the Prenatal Program Coordinator in CFHI Branch or are referred to the LHDs for issues related to specific services.

The majority of calls sent to Women's Health come from patients seeking free or low-cost mammograms or Pap tests. WIC calls typically are inquiries on how to find a local WIC office or how to apply for WIC. It is infrequent that calls regarding prenatal services are received on the hotline. As of January 1, 2010 we have received approximately 1,000 calls.

/2012/ In July, 2010, the KY Department for Medicaid Services distributed a list of 800 #s to women and children who receive Medicaid services and may need to apply for MCH services. DPH estimates receiving approximately 1,000 calls since the release of the list. MCH receives calls daily regarding application for WIC services and how to contact their local county DCBS office. //2012//

MCH has notified LHDs of the opportunity for KY women to participate in the National Text 4 Baby initiative. This program communicates with prenatal women and new mothers by texting to their cellular telephones messages to remind them to take their Folic Acid, prenatal vitamins, or that it is time to take their newborn to a provider for routine check-ups or immunizations. To be a recipient of these free messages, women must use specified cellular telephone companies.

KY Early Childhood Systems Collaborative: KY has had structure for both formal and informal collaboration among early childhood partners for over a decade. In 2000, landmark legislation created the Early Childhood Development Authority to oversee and coordinate KY's early childhood programs, and committed 25% of KY's Phase I Tobacco Settlement dollars to fund the early childhood initiative known as KIDS NOW (Kentucky Invests in Developing Success NOW!). The Early Childhood Development Authority is a public-private partnership with diverse membership including many of the agencies listed below as well as child care directors, Head Start directors, United Way, business leaders, and academic experts in early childhood. The group developed a mission, vision and 20 year plan for early childhood programs in KY. KIDS NOW encompasses many early childhood programs across many departments and divisions, including public health, child welfare, mental health, substance abuse, child care, child care subsidy, Child care Quality Rating Systems, Child Advocacy centers, early childhood education & Pre-school, Part C early intervention, Head Start, and Early Childhood professional development.

In addition this body oversees 65 Community Early Childhood Councils, who coordinate these services at the local level.. The Early Childhood Development Authority meets quarterly to review the progress of programs including program evaluation results as well as budget. In addition, program leads meet quarterly in "Implementation meetings" to assure collaboration across programs. The HANDS state-wide Home Visiting program has been one of the programs overseen by the Early Childhood Development Authority and integrated into this collaborative. Last year the Governor formed a Task Force on Early Care and Education which has done an inventory of early childhood programs in the state and is currently formulating recommendations for the Governor. In addition, the state is now applying for funding to develop a State Early Childhood Advisory Council, based on the infrastructure and expertise already developed by the Early Childhood Development Authority as described above. The Early Childhood Comprehensive Systems (ECCS) Grant will enhance the the development of a comprehensive plan through a fiscal mapping process which should be completed in early 2011. In addition, early childhood partners in the state are currently collaborating on a systems-building grant for early childhood mental health thru SAMSA in selected areas of the state.

/2012/ Office of Health Equity Initiatives:
REACH (Racial and Ethnic Approaches to Community-Based Health)
Is a project funded by the University of Alabama through the CDC to target African-American women in KY. Project staff conduct community outreach and health education for early screening of breast and cervical cancer. Community Health Outreach Workers (CHOWs) working with trained patient navigators identify hard-to-reach and never screened women and host trainings for

community leaders to help identify the target population.

Cultural Competence Assessment
The OHE conducted an organizational assessment of the LHDs across KY to assess the capacity to deliver culturally and linguistically appropriate services, implementation of appropriate policies and ability to recruit a diverse workforce. Based on study results nurse leaders stood out as the professionals that is best able to deliver appropriate services. Technical assistance and trainings are being provided to LHDs to enhance polices, recruitment and funding to better deliver services. This effort also met with Public Health Accreditation Board (PHAB) standards.

Health Equity Network
The Health Equity Network is a coalition funded by the Office of Health Equity through the Promoting Health Equity grant to raise community awareness about health disparities. The coalition serves primarily the Lexington-Fayette County area and consists of partners from local hospitals, departments of health, non-profit organizations, and community volunteers. The Network will hosts its inaugural Summit to educate the community on how to develop solutions to closing gaps in health outcomes for health equity.

A Healthy You
A project based on the US DHHS Office of Minority Health A Health Baby Begins With You, peer education campaign to raise awareness around infant mortality among African-American college students. //2012//

/2013/ The KY OHE partners with Workforce and Economic Development, Governor's Office of Minority Empowerment, Housing Authority, Parks and Recreation, Education, Transportation and Corrections in addressing the Social Determinants of Health (SDOH) in an effort to create a supportive environment to enable systems change. The SDOH encompass economic, environmental and social factors that contribute to population based health. The OHE is facilitating a workgroup looking across the life span from early pregnancy and childhood to older adults and how where we live work learn play and pray impacts our health. Goals include increasing awareness regarding SDOH issues and their impact on health outcomes, strengthening partnerships, advocating for and defining public policy to achieve health equity and increasing the number of prevention programs or policies that address SDOH.

Data is being collected related to social determinants and its impact on health outcomes to identify gaps, if any, as we create a framework for addressing SDOH in KY. //2013//

G. Technical Assistance

As a result of information coming out of KY's needs assessment process, we are collaborating with partners from other departments on several issues and would benefit from technical assistance on the following:
(numerical, not priority order)

(1) Assistance on identifying and or developing prevalence data or estimates on the extent of substance abuse at both the state and county level, and assistance with exploring evidence based strategies for primary prevention efforts. In order to objectively and effectively address the issues we must understand clearly where the state is in severity. Clarity of data will assure prevention strategies can be developed and targeted to areas with the highest likelihood for impact. While availablity of treatment is a known issue, it woudl be our hope that primary prevention efforts could decrease the need for such services.

(2) Assistance with exploring models of primary prevention for child abuse and maltreatment, specifically Triple P and possibly others. Child maltreatment is one of the most preventable causes of death for Kentucky children, and a growing need in Kentucky. Although many programs

for recognition of child maltreatment currently exist throughout the state, we believe this problem will improve through primary prevention strategies. We have community partnership availble and interested in testing and implementing such strategies at the community level, and DPH, Dept of Community Based Servcies, and Dept of Behavioral Health are all interested in promoting prevention strategies in communities and at the state level.

(3) Assistance with improving infant mortality data from NCHS or the CDC would benefit our efforts to more accurately determine infant deaths in Kentucky, as our current reporting is likely a significant underestimation of the problem in KY. Without accurate data, it is difficult to raise the importance of infant mortality with policy makers and to develop and target specific strategies to address the issue.

(4) Assistance with redesigning programs to promote resilience and strengths-based approaches. Those programs where we have utilized these approaches are much more successful than traditional programs that are directive and based on our understanding of the problem, not the patient's needs or desires for understanding the problem.

While CCSHCN would like to participate in programs above, we would also like to expand by refining a process to:
1. Collect data on all programs;
2. Evaluate the data;
3. Measure program effectiveness;
4. Provide guidance;
5. Adjust or modify interventions; and
6. Reporting out results to all interested parties.

/2012/ For the FY12 grant cycle, DPH is requesting technical assistance in the areas of child maltreatment and substance abuse in pregnant women and youth. These requests will assist the state in reviewing current data and processes. Kentucky will ascertain if exiting programs adequately address the needs of these populations and seek guidance on best practices for increasing public awareness and interventions.

With stronger collaboration between the Maternal and Child Health (MCH) Division, the Department for Community Based Services, and Prevent Child Abuse Kentucky, much needed detail and awareness surfaced in 2010. Through technical assistance from the Child Safety Network it is the intention of Kentucky to assess current awareness and intervention strategies to determine areas of improvement using best practices.

Through the partnership between the MCH Division and the Division of Behavioral Health, Kentucky plans to assess current substance abuse awareness, intervention, and treatment strategies so that early detection of illicit substance use by pregnant women and youth will improve health outcomes for these individuals as well as birth outcomes in KY. Through technical assistance the state anticipates best practices are in place or will be initiated. MCH partners with DBH in many programs for early childhood to determine and address developmental and mental health issues. //2012//

/2013/ KY did not request technical assistance in FY12 but chose to foster existing iniatives and work closely with regional partners to determine the best use of TA funds. The state continues to plan to request TA, either as a regional entity in infant mortality prevention and safe sleep efforts, or in state-specific areas such as child maltreatment. //2013//

/2013/ CCSHCN anticipates requesting technical assistance in the area of developing a road map toward establishing effective structures of needs assessment and problem resolution. While assessment and planning may seem to be simple processes, CCSHCN finds that the agency may benefit from a more purposeful approach toward establishing

methodologies and protocols for getting to the root of issues that face families of CYSHCN, and taking action steps designed to address these problems. By advancing such an approach, CCSHCN is hopeful that reporting data on agency objectives and performance measures will be more focused.//2013//

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2011		FY 2012		FY 2013	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	11354415	10111574	11354415		11131292	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	34342500	29272628	39540300		36355790	
4. Local MCH Funds *(Line4, Form 2)*	0	0	0		0	
5. Other Funds *(Line5, Form 2)*	41333300	17439286	18592000		17976900	
6. Program Income *(Line6, Form 2)*	0	0	0		0	
7. Subtotal	87030215	56823488	69486715		65463982	
8. Other Federal Funds *(Line10, Form 2)*	144893800	124417734	143818400		142853466	
9. Total *(Line11, Form 2)*	231924015	181241222	213305115		208317448	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2011		FY 2012		FY 2013	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	12828132	8353053	10214547		9623205	
b. Infants < 1 year old	12962474	8466700	10353521		9754133	

c. Children 1 to 22 years old	21634451	14149049	17302192		16300532	
d. Children with Special Healthcare Needs	32282586	21081514	25779571		24287137	
e. Others	6025113	3920821	4794583		4517015	
f. Administration	1297459	852351	1042301		981960	
g. SUBTOTAL	87030215	56823488	69486715		65463982	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	101100		170700		65357	
c. CISS	140000		218600		150000	
d. Abstinence Education	0		0		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	144091600		141296100		132137900	
h. AIDS	0		0		0	
i. CDC	561100		510000		0	
j. Education	0		0		0	
k. Home Visiting	0		0		10320305	
k. Other						
Birth Defects Regist	0		180000		179904	
Home Visiting	0		1443000		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2011		**FY 2012**		**FY 2013**	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	39227650	25570570	31269022		29458792	
II. Enabling Services	25056601	16478812	20151147		18984555	
III. Population-Based Services	16472745	10796463	13202476		12438157	
IV. Infrastructure Building Services	6273219	3977643	4864070		4582478	
V. Federal-State Title V Block Grant Partnership Total	87030215	56823488	69486715		65463982	

A. Expenditures

Budget projections for this section are completed before the state fiscal year actually closes. Budgets for various activities should be considered "point-in-time" estimates however, staff completing this portion of the Title V provides as accurate information as is possible at that time.

Actual expenditures may also be different than budget because of carryover and the variance of

grant years. The state fiscal year begins on July 1st and ends June 30th. The federal grant year (Title V) begins October 1st and ends September 30th. Many department grants have yet other timeframes. Difference may also be due to additional expenditures related to additional revenue and numerous budget adjustments (both positive and negative) for the year. We are unable to amend expenditures to reflect this. Details are available upon request.

Kentucky has a constitutional amendment requiring a balanced budget at the end of each fiscal year. In the current economic climate, this remains challenging.

Expenditures have remained relatively constant for Title V funds. The exceptions were minor and include:
•Form 3 shows increased expenditures in 2008 under Other Federal Funds due to additional Federal WIC funds and other carry forward dollars were added during 2008.
•Form 4 under All Others in Section 1. Federal-State MCH Block Grant Partnership included Federal funds that cross state fiscal years; these unexpended funds were used in early 2009.
•Form 5 had no significant trends noted since 2008. Funding from the Commission for Children with Special Health Care Needs had been overlooked prior to 2008 and has been included since that time.

/2012/ The majority of expenditures remain lower than budgeted funds for 2010 due to the difference in Kentucky's fiscal year and the federal grant year. Remaining funds are allocated for the first quarter of the new state fiscal year. Adjustments are being made to accomodate changes in other funding streams that directly affect MCH programs. //2012//

B. Budget

Both the Division of Maternal and Child Health (MCH) and the Commission for Children with Special Health Care Needs provide a discussion of the FY11 budget within this section. The majority of Title V Block Grant funding, after giving 34.9% to the Commission, is allocated by the MCH Division to local health departments to support community programs that work toward attaining MCH performance and outcome measures. In addition to MCH Title V funding, the health departments receive revenue from several major sources including other state general funds, federal grants, KIDS NOW Early Childhood Initiative, KCHIP, Bioterrorism, and local tax dollars.

Based upon the current estimated block grant allocations to Kentucky in FY11, (total of $11,354,415) 34.9%, or $3,962,691, will be contracted through a memorandum of agreement with the Commission for Children with Special Health Care Needs and the remainder of $7,391,724 will remain with the Department for Public Health.

For FY 11, the majority of this funding will be re-allocated through a block grant process to local health departments. From the allocations, local health departments have the ability to select particular cost centers in which to use the funds, which include clinical (direct patient services) or community (population-based) services. Clinical services include well-child, maternity and prenatal care, family planning, oral health and nutrition services. Approximately 90% of Title V funding is used to cover local health department clinical services. Some of the Community Services implemented by local health departments include prenatal classes, physical activity campaigns in schools, teen pregnancy prevention programs, injury prevention activities and smoking cessation campaigns. Approximately 10% of Title V funding is used to cover community services.

Funding in FY 09 was discontinued to support the Mental Health/Mental Retardation Suicide Prevention personnel ($14,000). This contract was reduced in previous years when the Department of Mental Health Mental Retardation received a $400,000 grant for Youth Suicide Prevention.

Current contractual agreements with major universities assist MCH programs with some direct care and infrastructure services, as well as data tracking and analysis, and education for local health department staff. These contracts are funded partially or entirely by the Block Grant. Funding has continued into FY11 for:

Custom Data Processing	$100,000
UK Infant Intensive Care Project	$260,550
UK Injury Prevention and Research	$112,608
UK MCH Institute	$42,900
UK Prenatal Training	$6,000
UK Young Parents Program	$143,200
UL Child Evaluation Center (Developmental Evaluation)	$422,300
UL High Risk Infant Follow-Up	$260,550
UL Maternal Mortality	$25,300
UL Pediatric Assessment/Well Child Program	$145,920

These contracts have been decreased in recent years and are continuing to decrease reflective of current budget trends.

For many years, DPH has placed special emphasis on physical activity and nutrition services for MCH populations. DPH directs funding to local health departments from the Preventive Services Block Grant, Healthy Communities Grant, and a portion of the Title V MCH Block Grant to underwrite activities addressing the issue of physical inactivity. In addition, $1 Million of the Title V block Grant is allocated for Medical Nutrition therapy in the local health departments, which includes interventions for diabetes and obesity. As obesity is a primary health concern for Kentucky's population, a combined use of these funds supports the ability of local health departments to address the unique needs of their communities.

Local health department allocations are based on a formula that takes into account population and need on a county-by-county basis. Funds are provided for clinical and community health and while certain programs are required (such as family planning, prenatal, SIDS grief counseling, child preventative, adult personal health and medical nutrition therapy), allocations for individual programs may vary depending upon community need as determined by a local needs assessment process. Throughout this process, MCH Title V funds must be used to meet MCH performance measures and applicable 2010 health objectives. The Title V Administrator works with the plan & budget review team who read each local health department plan and verify the proper use of MCH funding as well as the effectiveness of planned activities. Below is a listing of how Kentucky's local health departments are using Title V funding during FY10-FY11. This is a projection based on program plans submitted by the local health departments, reviewed and approved by program staff.

(CC 712) Dental Clinical Services	$385,809 (9%)
(CC 800) Pediatric Well-Child	$3,383,584 (75%)
(CC 802) Family Planning	$278,139 (6%)
(CC 803) Maternity	$2,500 (<1%)
(CC 805) Nutrition	$47,552 (1%)
(CC 818) Community Activities	$289,318 (6%)
(CC 857) Physical Activity	$94,595 (2%)

TOTAL: $4,481,497

Other federal funding Kentucky receives for MCH includes:

SSDI	$101,100
CISS	$140,000
WIC & WIC Food	$144,091,600

CDC for Childhood Lead	$561,100

TOTAL: $144,893,800

MCH State non-federal funding includes:

Program	Amount
MCH	$10,031,700
Oral Health	$877,600
KEIS	$13,095,300
Genetics	$469,600
Newborn Screening	$151,600
Nutrition	$50,800
HANDS	$7,719,100
Reach Out and Read	$215,100
Healthy Start in Child Care	$640,100
Early Childhood Mental Health	$775,000
Early Childhood Oral Health	$216,600
Early Childhood KEIS	$100,000

TOTAL: $34,342,500

There are no significant budget variations to report. See Expenditures section for details on variations in expenditures.

Commission for Children with Special Health Care Needs

The fiscal condition of the Commonwealth of Kentucky continues to be compromised as the result of low revenue projections and the rising costs of services. In spite of this situation, CCSHCN has made a commitment to preserve infrastructure and continue to serve those who are most in need. This requires careful prioritization, reliance upon partnerships and a heightened awareness of community resources.

In addition to MCH Title V Block Grant dollars, the CCSHCN receives funding from the state general fund (which includes Tobacco Settlement funds), agency funds, a CDC grant and two HRSA grants. The agency revenues are generated by dividends, a Medicaid cost report settlement, and third party/patient billings for direct patient care and care coordination.

While CCSHCN's total budget for FY2011 has increased by 10% over the FY2006 level, the revenue mix has changed radically. State general funds have decreased by 10.28%, federal funds have decreased by 3.74%, and CCSHCN has had to rely on its ability to generate agency funds which has increased by 49.42%. CCSHCN has been able to do this primarily by decreasing services to the underinsured population and increasing the number of patients with third party insurance coverage. CCSHCN expects these trends in state general funds to continue for a number of years going forward, however, the CCSHCN feels certain that the state and agency funds required for the 1989 maintenance of effort level of $8,170,428 will continue to be available into the foreseeable future.

/2012/ For FY12, the following update to contractual agreements is provided:

Custom Data Processing	$ 145,000
OIG/AFM Desk Audits	$ 17,768
Birth Registry	$ 82,917
Infant Intensive Care Project	$ 221,468
Injury Prevention & Research	$ 112,608
Maternal & Child Health Workforce	$ 42,000
Pediatric Training	$ 6,000

Prenatal Training	$ 6,000
Young Parents	$ 121,720
Child Evaluation/Community Evaluation	$ 390,628
High Risk Infant Follow-up	$ 221,468
Maternal Mortality	$ 25,300
Pediatric Assessment/Well Child Training	$ 145,920
Local Health Departments	$ 3,400,000
Lead	$ 402,453
Maternity	$ 795,430
Nutrition	$ 642,783

TOTAL: $10,742,163

Contract amounts reflect current budget trends.

Below is a listing of how Kentucky's local health departments used Title V funding during FY10-FY11. At this time local health department budgets have not been finalized for FY11-FY12.

(CC 712) Dental Clinical Services	$ 189,303	(3%)
(CC 800) Pediatric Well-Child	$ 2,870,733	(50%)
(CC 802) Family Planning	$ 679,763	(12%)
(CC 803) Maternity	$ 935,800	(16%)
(CC 805) Nutrition	$ 805,350	(14%)
(CC 818) Community	$ 133,075	(2%)
(CC 852) Resource Persons	$ 58,417	(1%)
(CC 857) Physical Activity	$ 20,559	(<1%)

TOTAL: $ 5,693,000

Other federal funding Kentucky receives for MCH includes:

SSDI	$ 170,700
CISS	$ 218,600
WIC/WIC Food	$ 26,015,900
CDC/Childhood Lead	$ 115,280,200
Education	$ 510,000
Other-Maternal, Infant & Early Childhood Home Visiting	$ 874,345

TOTAL: $ 143,069,745

MCH State non-federal funding includes:

Program	Amount
MCH	$ 9,333,200
Oral Health	$ 874,400
KEIS	$ 12,835,200
Genetics	$ 364,200
Newborn Screening	$ 221,700
Nutrition	$ 54,100
HANDS (no longer matched due to federal home visitation grant)	$ - 0 -
Reach Out & Read	$ 225,000
Healthy Start	$ 1,069,800
Early Childhood Mental Health	$ 938,400
Early Childhood Oral Health	$ 389,200
Early Childhood KEIS	$ 502,700

TOTAL: $ 26,807,900

There are no significant budget variations to report for this grant cycle.

Commission for Children with Special Health Care Needs

The decrease in smoking rates has reduced the amount of Tobacco Settlement dollars available for distribution to the earmarked children's health programs. CCSHCN lost its entire allotment of $350,000 and it is questionable as to whether it will be restored. The state general fund dollars were also decreased for employee furlough days (totaling 2.3%) plus as additional 2.6% of the originally enacted amount. The current outlook for actual revenues during the past few months have greatly exceeded the original budget projections so hopefully we will not see additional cuts in the next fiscal year.

The introduction of Medicaid Managed Care to all regions of the state (contracts awarded July, 2011, with target implementation date of October, 2011) will have a significant impact on CCSHCN's ability to generate agency funds. This past year, nearly half of the agency's operating costs were derived from this revenue source. Under the managed care model, total agency revenues are projected to decline by approximately $1,000,000 or 7% of the total operating budget.

CCSHCN was fortunate to be awarded a HRSA State Improvement Grant for the next three years which will be a great support to the organization's infrastructure and ability to improve the MCH core outcomes. CCSHCN was also invited to partner with the Department of Public Health in their SSDI grant to improve data systems and the exchange of health data.//2012//

/2013/ Tobacco Settlement dollars were partially restored during this fiscal year, however, CCSHCN has been notified that those monies will be completely phased out after next fiscal year. These funds have been used exclusively to support audiologist salaries for the Early Hearing Detection and Intervention program, therefore, CCSHCN will have look for ways to reduce costs while ensuring that children have access to these screening and evaluation services.

Even though economic indicators have been showing signs of recovery, Kentucky continues to have a shortage of available funding. General fund dollars were reduced an additional 3.5% this past fiscal year plus legislation was passed to push the last payroll cycle into the FY13 budget period. Additional budget cuts are anticipated as the ARRA funds which have been providing additional support to other critical programs begin to sunset.

During contract negotiations with the Medicaid MCOs, CCSHCN was fortunate to secure full cost report settlements with each contracting entity for at least the first three years. This will allow the agency to maintain the current levels of agency funds which account for nearly half of the overall funding for the program. //2013//

/2013/ For FY13, the following update to contractual agreements is provided:

Commission for Children with Special Health Care Needs (MOA)	***$3,884,821***
CDP	***$145,000***
UK Infant Intensive/Perinatal Quality Collaborative	***$ 221,500***
UK Injury Prevention	***$ 112,600***
UK MCH Workforce and DPH Policy Development	***$ 42,000***
UK Pediatric Training	***$ 6,000***
UL Child Evaluation	***$ 332,000***
UL High Risk Infant Follow-up	***$ 221,500***
UL Maternal Mortality	***$ 25,300***
UL Pediatric Assessment/Well Child	***$ 145,900***
UL Prenatal Training	***$ 7,500***
TOTAL:	***$5,144,121***

DPH is restructuring to a Core Public Health Service design in order to assist LHDs better address their unique community needs. This model will foster strong community partnerships, enhancing the movement of the overall health of state. It will also highlight the importance of Public Health carried out by the local health department as a major partner in the community's health care delivery system.
At this time, allotments are provided to LHDs to fund only core public health services. Below is a listing of how KY's LHDs will use Title V funding during FY12-FY13. At this time LHD budgets have not been finalized for FY13.

LHDs (MCH Coordinators 766)	***$3,714,533***
LHDs (MCH BG Support 876)	***$ 46,100***
LHDs (Nutrition 805)	***$ 642,800***
TOTAL: ……	***$4,403,433***

Other federal funding KY receives for MCH includes:

SSDI	***$65,357***
CISS	***$150,000***
WIC/WIC Food	***$132,137,900***
CDC/Childhood Lead	***0***
Education	***0***
Other-Maternal, Infant & Early Childhood Home Visiting	***$10,500,209***
Total: ……	***$142,853,466***

MCH State non-federal program funding includes:

Program	***Amount***
MCH	***$9,150,600***
Oral Health	***$838,700***
KEIS	***$12,387,800***
Genetics	***$269,200***
Newborn Screening	***$220,000***
Nutrition	***$40,300***
HANDS **	***$ 8,583,200***
Reach Out & Read	***$100,000***
Healthy Start	***$660,000***
Early Childhood Mental Health	***$820,200***
Early Childhood Oral Health	***$80,700***
Early Childhood KEIS	***$0***
Total……	***$15,416,900***

There are no significant budget variations to report for this grant cycle. **HANDS money is not used for the match or maintenance of effort in the MCH block grant, but is used for maintenance of effort in the Home Visitation Grant. //2013//

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.